# Petition

81-264

No.

Office Supreme Court, U.S.
FILED
AUG 10 1981
ALEXANDER L. STEVAS,

In The

# Supreme Court of the United States

October Term, 1981

PRESBYTERIAN HOSPITAL OF DALLAS,

*Petitioner,*

*v.*

RICHARD S. SCHWEIKER, Secretary of Health and Human Service,

*Respondent.*

## PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

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## Question Presented

When in Presbyterian Hospital of Dallas, are Medicare patients entitled to the use of telephone and television as a means of communication protected by the First Amendment; or, should they be denied these services unless they pay extra for them as "personal comfort" items?

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## Opinions Below

The Provider Reimbursement Review Board (PRRB) decision in Presbyterian Hospital of Dallas (Presbyterian) versus Blue Cross Association Group Hospital Service, Inc., (Blue Cross) rendered on February 28, 1979, was reported in *CCH Medicare and Medicaid Guide* ¶29653. (A-25) The Secretary of Health, Education, and Welfare had delegated his right of review to the Administrator of the Health Care Financing Administration who declined to reverse, affirm, or modify the PRRB decision by letter of April 25, 1979. (A-24) The judgment in the United States District Court and the unreported opinion of that date are reproduced in the Appendix. (A-21 and A-22)

The judgment in the United States Court of Appeals dated March 13, 1981, is reproduced in the Appendix (A-18); and the opinion rendered on that date, 638 F.2d 1381, is reproduced in the Appendix. (A-1)

An order granting an extension of time to file petitions for rehearing and petitions for rehearing en banc was granted, (A-19), and these petitions were denied on May 11, 1981. This order is reproduced in the Appendix. (A-20)

## Jurisdiction

Presbyterian seeks to review the adverse ruling of the Fifth Circuit on its claim for reimbursement of telephone and television expenses furnished Medicare patients.

The dispute between Presbyterian and Blue Cross was heard before the PRRB under provisions of 42 U.S.C. 1395oo, (A-59) and the PRRB's decision ruling against Presbyterian was rendered on February 28, 1979 (A-25) with a dissenting opinion by Commissioner Owens. (A-44) This decision was confirmed by the letter of April 25, 1979. (A-24)

Presbyterian filed suit in the United States District Court for the Northern District of Texas, Dallas Division, on April 26, 1979. (A-88) In that complaint Presbyterian claimed jurisdiction under the provisions of 42 U.S.C. 1395oo(f)(1) (A-88) and claimed that the Secretary's regulation denying payment for telephone and television service furnished to Medicare patients was unconstitutional as a violation of the patient's right of free communication protected by the First Amendment. (A-94)

The district court sustained the Secretary's motion for summary judgment. Presbyterian appealed to the United States Court of Appeals for the Fifth Circuit which rendered judgment on March 13, 1981, denying Presbyterian's claim for telephone and television.

The jurisdiction of this court is invoked under the terms of 28 U.S.C. 1254(1). (A-57)

## Constitutional Provisions, Statutes, and Regulations Involved

This case involves the following constitutional provisions, statutes, regulations, and orders: The First Amendment to the Constitution of the United States; 28 U.S.C. 1254(1); 42 U.S.C. 1395; 42 U.S.C. 1395c; 42 U.S.C. 1395f; 42 U.S.C. 1395y(a)(6); 42 U.S.C 1395oo; and tangentially the Civil Rights of Institutionalized Persons Act, PL 96-247.

It also involves 42 CFR 405.310(j) and the provisions of Medicare Intermediary Letter Part A-80-35 and Part B-80-28, Order for Toll Free Numbers. (A-73)

The pertinent text of the foregoing are set forth in the Appendix.

## Statement of the Case

In the audit by Blue Cross, following the close of fiscal year September 30, 1976, Presbyterian claimed that it should be reimbursed for telephone and television service which it had furnished to Medicare patients. It is a new hospital and every room is equipped with telephone and television service which is furnished to all patients without an extra charge. Acting pursuant to the Secretary's regulation, 42 CFR 405.310(j) (A-73), the Intermediary denied all expenses for the telephone service and 90% of the expense for television.

The claim for telephone and television, together with claims for reimbursement of the Medicare share of the Hill-Burton obligation to provide free care, and the claim for the right to charge as an expense the cost of interest paid during the construction period were presented to the PRRB which ruled against Presbyterian on all points. (A-25) Following the affirmation of this decision by the Secretary, (A-24), suit was filed in District Court. (A-88) Presbyterian dropped its claim to expense construction interest, and the District Court ruled against it on the two remaining points, dismissing the suit. (A-21 and A-22) Presbyterian appealed to the United States Court of Appeals for the Fifth Circuit which on March 13, 1981, rendered a decision requiring the Secretary to reimburse Presbyterian for the Medicare patients' share of Presbyterian's expense in providing free care under the Hill-Burton obligation; but, reasoning under *Harris v. MacRae*, No. 79-1268, ..... U.S. ....., 100 S.Ct. 2671 (1980), the Fifth Circuit held that Medicare patients were not entitled to telephone and television service. This conclusion was reached on the grounds that the indigency of these patients caused them not to have these means of communication to protect First Amendment rights. (A-1)

Presbyterian respectfully petitions this Court for a Writ of Certiorari to the Court of Appeals for the Fifth Circuit to review this portion of this judgment relating to its claim that Medicare patients have a right under the First Amendment to the use of telephone and television service and a judgment that it should be reimbursed for its expense in providing these means of communication.

## REASONS FOR GRANTING WRIT

This case presents squarely the issue: When in a hospital, are Medicare and Medicaid[1] patients entitled to the use of a telephone and television as a means of communication protected by the First Amendment? It presents the claim of Presbyterian for reimbursement of its expense in providing telephone and television service to its Medicare patients. Of vastly greater importance will be its effect on the rights of more than 17,000,000 people over 65 years of age who are eligible for Medicare and the manner in which future hospital construction and remodeling will be done throughout the United States. The question of free speech presented here does not involve obscenity, abortion, or the rights of unpopular minority groups to demonstrate against duly constituted authority. It is clean free speech — the right to talk to relatives, friends, business associates, and doctors; to receive news, educational, entertainment, and religious programs. Also, the case is singularly unique and legally important because it has the Secretary — the govern-

[1]The term "Medicare" has been used as a reference throughout the history of this case; however, a small portion of Presbyterian's patients were under the "Medicaid" program. "Medicare" will be used hereafter to refer to both categories of patients in most cases.

The Fifth Circuit decision following *Harris v. McRae* will require a discussion on the rights of Medicaid patients for means of communication; Presbyterian urges that there is no reason for a distinction.

ment — urging a most restrictive interpretation of the rights of the Medicare patients under the First Amendment contrary to its usual position on this subject.

This case arises directly from the action of the Secretary of Health, Education, and Welfare in construing: "42 U.S.C. 1395y (a) (6) — **Exclusions from Coverage:**

* * *

> "(a) Notwithstanding any other provisions of this subchapter, no payment may be made under part A or part B of this subchapter for any expenses incurred for items or services —
>
> * * *
>
> "(6) which constitute *personal comfort items;*" (emphasis added)
>
> * * *

to read as found in: "42 CFR § 405.310 **Types of expenses not covered.**

> "Notwithstanding any other provision of this Part 405, no payment may be made for any expenses incurred for the following items or services —
>
> * * *
>
> "(j) Personal comfort items and services (*for example a television set, or telephone service, etc.*)"; (emphasis added)

This case presents for the first time a claim that the interpretation by the Secretary in equating personal comfort items to telephone and television service and thereby refusing payment for these expenses is unconstitutional. No individual, no group, and no hospital as a provider of health care has raised this point heretofore. The opinion of the Fifth Circuit in confusing the Medicare program, one of compulsory insurance for everyone, with the Medicaid program, a form of relief for the needy, makes it most unlikely

that the claim will be asserted again unless the Court grants a Writ of Certiorari to correct this error. Further, the Court should clarify the rights of all those who are eligible for Medicare to have reasonable means of communication when they are confined in a hospital.

The committee reports on the Medicare Act (p. 1965, A-82) state that 17,000,000 people with varying forms of insurance were covered and 2,000,000 more would be covered in 1966. The number of people eligible for this protection has increased, but lacking current figures Presbyterian simply states that it involves nearly all American citizens over 65 years of age. 42 U.S.C. § 1395c

The Court has repeatedly held that First Amendment rights must be applied in the light of the special characteristics of the environment. *Tinker v. Des Moines Independent Com.Sch.Dist.*, 393 U.S. 503, 505, 506 (1969). *Healey v. James*, 408 U.S. 169, 180 (1972). The cases involving the fundamental rights of prisoners developed under the doctrine established by these cases; similarly, the Secretary should recognize the First Amendment rights of Medicare patients and provide for their reimbursement to the hospital.

Presbyterian urged the analogy between the rights of Medicare patients and prisoners. It did not meet with favor in the lower courts; but the Court held in *Wolff v. McDonnell*, 418 U.S. 539, 555 (1974), that there was no iron curtain drawn between the Constitution and prisons of the country. Similarly, the Court has held that prisoners retain those First Amendment rights that are not inconsistent with their status as prisoners or with the legitimate penological objectives of the corrective system. Restrictions that inhibit First Amendment rights must be analyzed in the terms and policies of the corrective system. *Pell v. Pro-*

*cunier*, 417 U.S. 817, 822 (1974). In *Maher v. Roe*, 432 U.S. 464, 470 (1977), the Court held that when a State decides to alleviate the hardships of poverty by providing medical care, the manner in which it dispenses benefits is subject to constitutional limitations. The Medicare program was intended by Congress to provide the best of medical care. (p. 1967, A-83) But, it places limitations on the program to prevent it from becoming a hotel. A patient can only receive benefits of the program if the physician certifies need for hospitalization. 42 U.S.C. § 1395f. Regulations were to be established, and they were, requiring assurances that hospitalization was needed. (p. 1986, A-86)

When the elderly citizen is sick enough to be certified for hospital admission, he should not be confronted with the dilemma of accepting the benefits of the Medicare program which he has been compelled to join and waive his rights of communication with the outside world or take treatment at home.

The Secretary's construction of 42 U.S.C. § 1395y(a) (6) may be considered as a disparagement of First Amendment rights made by oversight. However, the only reference to television is found on p. 1969, A-84. No mention is made of telephone service; but, television became expanded to language quoted above in place of "such potential personal comfort items and services as massages, and heat lamp treatments." (p. 1989, A-87) If this were an oversight, it is of such importance that it could have been corrected easily when Presbyterian's complaint was served on the Secretary. Presbyterian's basic suspicion that the translation from massage and heat lamp to telephone and television was done on the basis of economy was confirmed by the memorandum of law filed by the Secretary stating that the financially

strained social security program can ill afford to pay for services which are not in truth needed for the health care beneficiaries. (A-97)

Changing the items of illustration is a debater's technique easily recognized; but, the skill of advocacy did not end there. By the time Presbyterian's case was heard by the PRRB television and telephone service were no longer referred to as "personal comfort items" but were now "luxury items furnished solely for the personal comfort of the patient". (A-36) The reference to luxury items has become quite established in the jargon of the regulations and the writings of HHS on this subject.

Presbyterian mentioned First Amendment rights in its Position Paper before the PRRB, but that board could not rule on the constitutionality of a statute or a regulation. That board totally failed to mention the problem, but it did deny the claim because of no scientific study, or statistical evidence on how these services impact on diagnosis or treatment of illness or injury.

The concurring opinions of Justices Marshall and Brennan in *Procunier v. Martinez*, 416 U.S. 396 (1974) found on page 427 apply equally to the situation of a patient confined to a bed in a hospital room which isolates him from the outside world.

The pejorative treatment of telephone and television outlined above is contradicted by the October Intermediary Letter from the Health Care Financing Administrator (A-73) which would require Blue Cross to provide toll free numbers for public inquiries about Medicare business. It is fair to speculate that the calls must be of major importance because the letter states that the anticipated volume is very low; but, then it proceeds to delineate minimum standards —

10% chance of a busy signal, 20 seconds for an answer, and 80% of the inquiries completed during the call.

Since both Presbyterian and Blue Cross are in Dallas where service is provided by Southwestern Bell Telephone, its patients would not use the toll free number. The calls must be of great importance but it takes the use of two instruments to complete the call. Presbyterian provides a "luxury" telephone at the bedside of every patient who may need to place the most important call on the toll free number.

This is one illustration of a call which a patient may need to make. Besides talking about his problems with insurance coverage and Medicare records, the patient may need to call members of the family, friends, business associates, and doctors.

The television set also provides a most valuable contact with the outside world. With the set positioned above the bed, he has the choice of programs — news, entertainment, education, and religious.

A decision by the Court in this case will lay to rest the claim of First Amendment rights. Either the patient has a right to these services which Presbyterian provides, and they will become a standard so that all Medicare patients have them, or the Secretary's ruling that these are personal comfort items of a luxury nature will be sustained and Presbyterian can start charging extra to each patient.

This question is of high importance to the people who may become Medicare beneficiaries and to the hospitals of the country. It has taken years for this contention to reach the point of final decision; and, the adverse holdings of the courts below make it most unlikely that any hospital or group of patients will undertake the long litigation to pre-

sent this issue for final decision if the Writ of Certiorari is not granted.

Presbyterian has a claim unique to itself. 42 U.S.C. § 1395 states that nothing in this subchapter shall be construed to authorize any Federal officer — to exercise any supervision or control over the administration or operation of any such institution, agency, or person.

Presbyterian's method of operation of its hospital provides telephone and television to all patients. If the Secretary refuses to pay for these "luxury" items, then Presbyterian has a choice of the following options. First, it can either provide these services to Medicare patients without receiving compensation shifting the burden of this cost to other patients. Second, it can establish special rooms reserved for Medicare patients where these services are not provided, or they are charged to the patient separately at an extra cost. Creating a special class of Medicare rooms in each department of the hospital creates a massive waste, and it also is a direct violation of the law and common sense. Third, Presbyterian can change its entire method of operation to provide no patients with telephone and television except when they are charged as separate items. This would involve moving these instruments up and down the hall from time to time and the installation of jack connections in every room. In a word, Presbyterian can wire around the First Amendment; but, this is a dreadful thing to do.

The Secretary's regulation is an attempt to save money but the Court has held that savings on welfare costs cannot involve an invidious classification of a residence requirement. *Shapiro v. Thompson*, 394 U.S. 618, 633 (1969) Similar arguments were raised in *Sherbert v. Verner*, 374 U.S. 398, 404 (1963), and in *Memorial Hospital v. Maricopa County*,

415 U.S. 250, 264 (1974). Constitutional right did not yield to attempt to protect the public fisc.

The Medicare-Medicaid programs should now be examined briefly. 42 U.S.C. § 1395c points out that the Medicare program is one of compulsory insurance. *Turecamo v. C.I.R.*, 554 F.2d 564, 571 (2nd Cir. 1977). All working persons pay into it. They become eligible for benefits upon attaining the age of 65 years and having the misfortune of a serious injury or illness which makes it possible for the physician to certify their need for hospitalization. 42 U.S.C. § 1395f. The Medicaid program assists the states in providing health care for the needy.

There should be no difference, certainly no significant difference, in the rights of the Medicare patient and the Medicaid patient insofar as the questions of telephone and television service are concerned. This distinction between the rights of a Medicare patient to care for which he has paid and the Medicaid patient who is receiving a form of relief is important now because the Fifth Circuit applied the reasoning in *Harris v. McRae* which held that the government does not have to provide indigent women (Medicaid patients) free abortions to reach the conclusion that the government is not required to provide telephone and television service to Medicare patients.

The claim for First Amendment rights in *Harris v. McRae* was based upon a claim of religious discrimination in favor of the Catholic church and others whose doctrine does not permit abortion. The right of free speech was not involved there.

In turn, there is nothing in the Medicare Act or any of the funding legislation subsequent thereto which says that

no funds shall be used to provide telephone and television service for a Medicare patient.

Presbyterian's only challenge is to 42 CFR 405.310(j) and the interpretation thereof; 42 U.S.C. § 1395y(a)(6) does not violate the First Amendment.

It was stated earlier that this case is unique because it has the government arrayed against free speech. In nearly every case in recent years it has been some agency of the government or the federal courts which have protected the First Amendment rights of minorities, prisoners, members of religious sects, etc. It is rare to find a situation where the Secretary is arrayed against the citizen; indeed it is amazing to find in this case that the Secretary is contesting the right of the Medicare patients to have a means of communication.

Of all parties, it would appear that this officer should have a fiduciary duty to protect the rights of the beneficiaries. It ill-behooves the government to claim a win on the question of free speech for Medicare beneficiaries by misconstruing the legislation. The program is one of compulsory insurance as mentioned above. A Medicare beneficiary may be crippled by an accident or stooped by illness, but he is entitled to claim the benefits of the program without the humiliation of admitting that he is a failure — needy and broken and now at the end of life in need of relief. He is not compelled to admit indigency, and it is wrong to classify any beneficiary of the Part A program in this manner.

The Secretary should have a natural curiosity to know whether telephone and television service are a constitutional right of the Medicare patient or are they luxury items available only to those who can pay extra. And, he should

also be particularly concerned not to claim a victory under the reasoning of the Fifth Circuit on the Medicaid case.

To call the more than 20,000,000 persons who are eligible for Medicare and those of the adult population who are paying for this benefit which they will receive in the future "indigents" — recipients of relief from the government — is a smirch which the Secretary should ask this Court to remove.

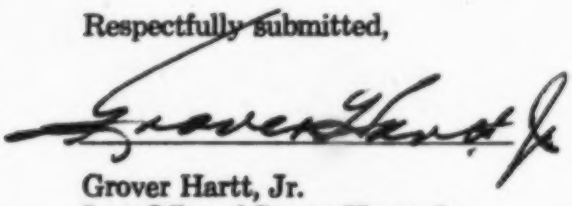
As mentioned above, Congress has never said that no funds can be expended to provide telephone and television service for Medicare patients. However, in 1980 Congress did pass Public Law 96-247, Civil Rights of Institutionalized Persons Act. (A-63) This may be tangentially relevant in determining the position of the government with reference to the civil rights of Medicare patients. The categories listed on A-63 do not include patients in a private hospital such as Presbyterian, but they do include beneficiaries of the social security program in skilled nursing, intermediate or long term care, or custodial or residential institutions operated by public agencies. It goes to considerable length in directing the Attorney General to protect the civil rights of persons in the institutions described there.

There is a genuine need to clarify the rights of all beneficiaries of the Medicare programs and the duties of the hospitals providing services to them. This writ should be granted. Also, it should be granted to remove the stigma of the indigency classification and to help the Secretary and those who may follow to administer the program correctly.

## Conclusion

This Court should grant a Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit and should reverse that part of the decision of that court holding that Medicare patients are not entitled to the use of telephone and television as a means of communication protected by the First Amendment.

Respectfully submitted,



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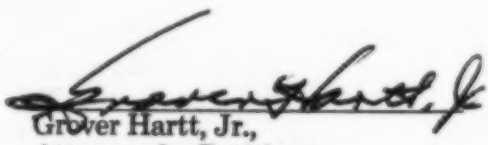
**Certificate of Service**

I hereby certify that four true copies of the foregoing Petition for a Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit were served on the Solicitor General of the United States, Room 5614, Department of Justice, Washington, D.C. 20530 and a copy was served on the General Counsel of the Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, D.C. 20201 by depositing the same in the United States mail with postage prepaid for First Class mailing service this 7th day of August, 1981.



Grover Hartt, Jr.,
Attorney for Petitioner

# Appendix

Office-Supreme Court, U.S.
F I L E D
AUG 10 1981
ALEXANDER L. STEVAS,
CLERK

81-264

No. .....

In The

# Supreme Court of the United States

OCTOBER TERM, 1981

PRESBYTERIAN HOSPITAL OF DALLAS

*Petitioner,*

*v.*

RICHARD S. SCHWEIKER, Secretary of Health and Human Service,

*Respondent.*

## APPENDIX TO PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT AFTER JUDGMENT

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# APPENDIX TO PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT AFTER JUDGMENT

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# PRESBYTERIAN HOSPITAL OF DALLAS v. HARRIS*

PRESBYTERIAN HOSPITAL OF DALLAS,

*Plaintiff-Appellant,*

*v.*

PATRICIA R. HARRIS, *Secretary of Health and Human Services,*

*Defendant-Appellee.*

No. 80-1589
Summary Calendar.

United States Court of Appeals, Fifth Circuit.
Unit A

March 13, 1981.

Hospital sought review of final decision by Secretary of Health and Human Services denying medicare reimbursement for certain expenses incurred by the hospital. The United States District Court for the Northern District of Texas, Robert M. Hill, J., entered judgment, and appeal was taken. The Court of Appeals, Randall, Circuit Judge, held that: (1) the free speech clause of First Amendment did not require the Department to reimburse, under medicare provisions of Social Security Act, hospital for television and telephone expenses incurred during medicare patients' covered hospitalization; but (2) free care expenses incurred by hospital in connection with its obligations under Hill-Burton Act to provide free medical care to indigents were reasonable costs of providing care to medicare patient and were reimbursable, even though recipients of such care were not medicare patients.

Affirmed in part and reversed in part with directions to remand.

* 638 F2d 1381

**1. Constitutional Law ☜ 90.1(1)**

**Social Security and Public Welfare ☜ 241.20**

The free speech clause of First Amendment did not require Department of Health and Human Services to reimburse under medicare provisions of Social Security Act, hospital for television and telephone expenses incurred during medicare patients' covered hospitalization. Social Security Act § 1862(a)(6) as amended 42 U.S.C.A. § 1395y(a)(6); U.S.C.A.Const. Amend 1.

**2. Social Security and Public Welfare ☜ 241.20**

Under medicare provision of Social Security Act, hospital was not required to provide to each patient services which were not covered by medicare and hospital was free to charge medicare patients costs of services which were not covered by medicare program, and thus claimed shifting to nonmedicare patients of burden of paying for medicare patients' television and telephone costs did not require that hospital be reimbursed under the Act for medicare patients' telephone and television expenses. Social Security Act, § 1861(v)(1)(A) as amended 42 U.S.C.A. § 1395x(v)(1)(A).

**3. Social Security and Public Welfare ☜ 241.20**

Free care expenses incurred by hospital in connection with its obligations under Hill-Burton Act to provide free medical care to indigents were reasonable costs of providing care to medicare patient and were reimbursable, even though recipients of such care were not medicare patients. Social Security Act, §§ 1814(b), 1861(v)(1)(A) as amended 42 U.S.C.A. §§ 1395f(b), 1395x(v)(1)(A).

**4. Administrative Law and Procedure ☜ 744**

De novo determination of factual question in judicial review of adjudicatory proceeding governed by Administra-

tive Procedure Act is authorized only if agency fact-finding procedures are inadequate; otherwise, courts must allow agency to decide for itself. 5 U.S.C.A. § 551 et seq.

**3. Administrative Law and Procedure**
**☜817**

Where error of law has been corrected by reviewing court, and only issues remaining in case are questions which have not yet been considered by administrative agency but are nevertheless within agency's authority, appropriate action is remand to agency so that it may exercise its authority. Social Security Act, § 1 et seq. as amended 42 U.S.C.A. § 301 et seq.

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Appeal from the United States District Court for the Northern District of Texas.

Before GEE, RUBIN and RANDALL, Circuit Judges.

RANDALL, Circuit Judge:

This appeal arises from an action brought by Presbyterian Hospital of Dallas (the Hospital) to seek review of a final decision of the Secretary of Health and Human Services (the Secretary) which denied medicare reimbursement for certain expenses incurred by the Hospital in 1976. In particular, the Hospital challenges (1) the disallowance of expenses incurred in the provision of television and telephone service to the Hospital's medicare patients, and (2) the disallowance of expenses incurred in the provision of free medical care to indigents, as required of the Hospital by the Hill-Burton Act. The United States District Court for the Northern District of Texas granted summary judgment in favor of the Secretary on both grounds. With respect to the first, we affirm the judgment of the district court. With respect to the second, we reverse the judgment of the district court and direct the district court to remand this case to the Secretary.

## I. THE FACTS

The Hospital is a private, non-profit acute care hospital located in Dallas, Texas. It is a qualified provider of medical services under Part A of the medicare provisions of the Social Security Act, 42 U.S.C. § 1395 *et seq.* (1976), and is therefore entitled to be reimbursed for the reasonable costs it incurs in the provision of necessary health services to medicare beneficiaries. 42 U.S.C. §§ 1395f(b), 1395x(v)(1)(A) (1976). In 1976, approximately 31% of the Hospital's patients were treated under the medicare program. As a medicare provider, the Hospital is entitled to monthly reimbursements from a fiscal intermediary of the Department of Health and Human Services. 42 U.S.C. §§ 1395g, 1395h (1976). There is no review of monthly reimbursements, 42 U.S.C. § 1395g, but at the conclusion of each fiscal year medicare providers must file a cost report with the intermediary. 42 U.S.C. § 1395g; 42 C.F.R. § 405.453(f) (1979). The intermediary may then retroactively adjust the payments it has made during the previous year. 42 U.S.C. § 1395g; 42 C.F.R. § 405.454(f) (1979).

The fiscal intermediary which reimburses the Hospital is Blue Cross of Texas (the Intermediary). After the Intermediary received the Hospital's cost report for the fiscal year ending September 30, 1976, it adjusted the amount due the Hospital for that year by reducing the Hospital's reimbursable expenses for, *inter alia*, the two items at issue here. The Hospital appealed the Intermediary's decision to the Provider Reimbursement Review Board of the Department of Health and Human Services (the Board), pursuant to 42 U.S.C. § 1395oo(a) (1976). The Board affirmed the decision of the Intermediary and, pursuant to 42 U.S.C. § 1395oo(f) (1976), the Board's decision became the final decision of the Secretary when the Secretary failed to modify or reverse the Board's decision within sixty days of its issuance. The Hospital then sought judicial review of this decision pursuant to 42 U.S.C. § 1395oo(f); accordingly, our standard of review is that set forth in the Administrative Procedure Act, 5 U.S.C. § 706 (1976).

The first issue on appeal involves the Secretary's refusal to allow reimbursement for television and telephone service. The Hospital's practice is to provide a television and telephone to all patients without an additional charge. In the fiscal year at issue, the Hospital claimed $6,062 in television rental and repair expenses, $2,657 for depreciation of television equipment, and $221,598 for telephone expenses. The Intermediary disallowed 90% of the television expenses and 34.72% of the telephone expenses. The Intermediary calculated the television disallowance percentage on the basis that 10% of patient use was "educational" and therefore reimburseable pursuant to 42 C.F.R. § 405.421 (1979); the telephone disallowance percentage was based on the ratio of patient telephone jacks to the total number of telephone jacks in the Hospital.

The second issue on appeal involves the Secretary's refusal to allow reimbursement for the expenses the Hospital incurred in fulfilling its free care obligation under the Hill-Burton Act, 42 U.S.C. § 291 *et seq.* (1976). The Hill-Burton Act provides an interest subsidy to hospitals on hospital construction and modernization loans, whereby the federal government pays directly to the lender 3% of the effective net interest per year. 42 U.S.C. § 291j-4 (1976). In order to qualify for this subsidy, however, the hospital must agree to provide a certain amount of free medical care to indigents. 42 U.S.C. § 291(c) (1976). As we explained in *Cook v. Ochsner Foundation Hospital*, 559 F.2d 968, 972 (5th Cir. 1977), "[t]he service to indigent patients is a *quid pro quo* exacted in return for the benefaction received from the taxpayers." The free care obligation is legally enforceable, and vests a cause of action in the indigent beneficiaries to sue for the free care. *Saine v. Hospital Authority of Hall County*, 502 F.2d 1033, 1034 35 (5th Cir. 1974). The obligation may be met in one of two ways: the hospital may agree to budget for uncompensated services to indigents not less than the lesser of 3% of its operating costs or 10% of all federal assistance received under the Hill-Burton Act, or it may agree that it will not exclude any person from admission

on the ground that that person is unable to pay for the needed services. 42 C.F.R. § 53.111(d) (1979). The Hospital chose the latter "open door" approach, and agreed to provide service to all indigents who presented themselves for care. The Hospital received approximately $225,000 in Hill-Burton interest subsidies during the fiscal year at issue. The Hospital sought to recover a total of $178,871 in expenses incurred in the provision of free care to indigents, and the Board disallowed this entire amount.[1]

## II. TELEVISION AND TELEPHONE EXPENSES

The Social Security Act specifically excludes "personal comfort items" from medicare coverage. 42 U.S.C. § 1395y (a)(6) (1976). Interpreting this provision, regulations of the Department of Health and Human Services list "a television set" and "telephone service" as examples of personal comfort items. 42 C.F.R. § 405.310(j) (1979). The Hospital does not seriously argue that this interpretation is beyond the authority of the Secretary.[2]

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[1]The Hospital did not originally claim reimbursement for its free care expenses. At first, it sought to include in its expenses the full amount of the interest payment made by the government under the Hill-Burton Act: the Hospital only asked for its free care expenses when reimbursement for the interest payment made by the government was denied by the Intermediary. The Hospital's initial position seems to have been based on its contingent liability for the entire interest payment, including that portion made by the government under the Hill-Burton Act. This argument was not, however, made before the Board.

[2]The Hospital does note that the examples of personal comfort items listed in 42 C.F.R. § 405.310(j), *i. e.*, "a television set" and "telephone service," are not precisely the same examples that are listed in the Senate Report on the Social Security Amendments of 1965, which included the provision which excludes personal comfort items. See S.Rep.No.404, 89th Cong., 1st Sess. (1965), reprinted at [1965] U.S. Code Cong. & Ad.News 1943. That report refers at one point to "[i]tems supplied at the request of the patient for his convenience, such as television rental in hospitals." [1965] U.S. Code Cong. & Ad.News at 1969. At another point it refers to "such potential personal comfort items and services as massages and heat

[1] Instead, the Hospital argues that medicare patients have a constitutional right, under the Free Speech Clause of the First Amendment, to government reimbursement of television and telephone expenses incurred during their covered hospitalization. We disagree. Assuming without deciding that the government is barred by the First Amendment from acting to *prevent* a hospital patient's access to television and telephone service, we think it clear that there is no constitutional obligation to *finance* such access. In *Harris v. McRae*, U.S. , , 100 S.Ct. 2671, 2688-89, 65 L.Ed.2d 1094 (1980) (holding constitutional the Hyde Amendment, which severely limits the reimbursement of abortion costs from medicaid funds), the Supreme Court explained the applicable principle:

> Although the liberty protected by the Due Process Clause affords protection against unwarranted government interference with freedom of choice in the context of certain personal decisions, it does not confer an entitlement, to such funds as may be necessary to realize all the advantages of that freedom. To hold otherwise would mark a drastic change in our understanding of the Constitution. It cannot be that because government may not prohibit the use of contraceptives, or prevent parents from sending their child to private school, [that] government therefore, has an affirmative constitutional obligation to ensure that all persons have the financial resources to

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lamp treatment." *Id.* at 1989. The first of these comments was made in connection with the Committee's discussion of the "reasonable cost of services" which is reimbursed pursuant to 42 U.S.C. § 1395f. and not in connection with the section 1395y exclusion at issue here. The second of these comments does appear to relate to the section 1395y exclusions, but was made in the context of a discussion of the first of those exclusions (expenses which "are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member"). These comments — which are the only facts raised on appeal by the Hospital in connection with the validity of the regulations — do not indicate that the regulations are beyond the authority of the Department of Health and Human Services.

> obtain contraceptives or send their children to private schools.

..... U.S. at ....., 100 S.Ct. at 2688-89 (citations omitted). The exclusion of television and telephone expenses from medicare coverage does not prevent access to television and telephone service, for the patient may pay for such service himself. Since the government is not required to finance the exercise of First Amendment rights, the government may exclude from medicare coverage costs which may in fact be used for such purposes.

The Hospital argues that the government is nevertheless constitutionally required to provide hospital patients with television and telephone service because of the restraints placed on their liberty by hospital confinement. For this proposition the Hospital relies on the First Amendment rights of prisoners. *See, e.g., Pell v. Procunier*, 417 U.S. 817, 822, 94 S.Ct. 2800, 2804, 41 L.Ed.2d 495 (1974). Hospital patients, like prisoners, do indeed have their liberty restrained. But the First Amendment analogy between hospital patients and prisoners is inapposite. As the Supreme Court explained in *Harris v. McRae*:

> [A]lthough government may not place obstacles in the path of a woman's exercise of her freedom of choice, it need not remove those not of its own creation. Indigency falls in the latter category. The financial constraints that restrict an indigent woman's ability to enjoy the full range of constitutionally protected freedom of choice are the product not of governmental restrictions on access to abortions, but rather of her indigency.

..... U.S. at ....., 100 S.Ct. at 2688. The conditions of prison confinement are undoubtedly created by the government. The conditions of hospital confinement, on the other hand, are the product of private choices. Admittedly, some patients have no reasonable option but to submit to hospitalization and to accept the government's financial

help, and some of these patients will be financially unable to pay the cost of television and telephone service. But the cause of these patients' inability to afford television and telephone service is their indigency, and that is a condition which, as the Supreme Court noted in *McRae*, is not of the government's creation. Therefore the government is not constitutionally required to fund a patient's access to television and telephone service.

[2] The Hospital also argues that the exclusion of television and telephone costs from medicare coverage shifts the burden for those expenses to non-medicare patients of the Hospital, since the Hospital's practice is to provide television and telephone service to all patients without individually charging each for his television and telephone. This result runs contrary, so the Hospital's argument runs, to the Social Security Act's policy against shifting costs for the treatment of medicare patients to individuals not covered by the program. *See* 42 U.S.C. § 1395x(v)(1)(A) (1976); 42 C.F.R. §§ 405.402(a), 405.420(d) (1979). We disagree. The fact that medicare does not cover television and telephone service does not obligate the Hospital to provide those services to all of its patients but to charge only non-medicare patients. The Hospital is not required to provide services which are not covered by medicare to each patient, and is free to charge medicare patients the costs of services which are not covered by the Program. *See Mount Sinai Hospital of Greater Miami v. Weinberger*, 517 F.2d 329, 335, 340 n.18 (5th Cir. 1975), *cert. denied*, 425 U.S. 935, 96 S.Ct. 1665, 48 L.Ed.2d 176 (1976).

## III. HILL-BURTON FREE CARE EXPENSES

As was noted in Part I of this opinion, the Hospital receives an interest subsidy under the Hill-Burton Act for certain loans contracted in order to provide funds for hospital construction and modernization. One condition of this subsidy is that the Hospital obligate itself to provide a certain amount of free medical care to indigents; the Hospital

fulfilled this requirement in the fiscal year at issue by agreeing to provide free care on an open door basis to all who requested care but could not pay for it. Under this arrangement, therefore, the Hospital incurs certain expenses for indigent medical care in exchange for an interest subsidy from the federal government which helps to finance hospital construction and modernization projects. These facts were accepted both by the Intermediary and by the Board. As the Board explains, no party disputes "the Provider's legal responsibility to provide free care pursuant to Hill-Burton requirements nor the value the interest subsidy has in relationship to enabling the Provider to render improved health care services." *Presbyterian Hospital of Dallas v. Blue Cross Association Group Hospital Service, Inc.*, Provider Reimbursement Review Board Decision No. 78-96, at 13 (Feb. 28, 1979).

[3] Nevertheless the Board denied reimbursement for the costs of the Hospital's free care obligation. Although the rationale behind the Board's decision is not altogether clear, it seems to rest on the assumption that reimbursement would be contrary "to the objective of determining reasonable cost whereby costs with respect to individuals covered by the program will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by the program." *Id.* The Board explains that, while "the cost of rendering the free care is a cost to the facility," the patients who receive the free care may not have any portion of the costs of their care borne by the medicare program, since the result would be that the medicare program would pay for care provided to non-covered patients. *Id.*

The Board correctly states the applicable principle, for the Hospital is entitled to reimbursement only for the reasonable cost of services provided to medicare patients. 42 U.S.C. § 1395f(b). Reasonable cost is defined in the Social Security Act as "the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in

the efficient delivery of needed health services." Reasonable cost is defined to include both direct and indirect costs, but the statute specifically states that costs are to be calculated so that "the necessary costs of efficiently delivering covered services to individuals covered by [medicare] will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by [medicare]." 42 U.S.C. § 1395x(v)(1)(A). *See* 42 C.F.R. § 405.451(c)(3) (1979).

However, the general principle on which the Board relies does not bar reimbursement for Hill-Burton free care expenses, for the Hospital is legally obligated to make such expenses and receives, in exchange for this obligation, a government subsidy which benefits all of the Hospital's patients, including those covered by medicare. Although the provision of free care pursuant to this obligation inures to the direct benefit of indigents rather than to medicare patients, it indirectly benefits medicare patients by qualifying the Hospital for federal interest subsidies on construction and modernization projects which are ultimately used by medicare patients. We find persuasive the logic employed by the United States District Court for the Western District of Louisiana, which faced this precise issue in *Rapides General Hospital v. Matthews*, 435 F.Supp. 384 (W.D.La. 1977), *vacated and remanded on other grounds*, No. 77-3125 (5th Cir., Oct. 23, 1978) (unpublished order). As that court explained:

> Defendant's opposition is a straightforward one. The indigents receiving Hill-Burton free care are persons other than those covered by medicare. Thus, their stature as "individuals not so covered" automatically precludes the plaintiff from receipt of medicare payments as to their costs. But this response misapprehends the thrust of plaintiff's argument. Plaintiff does not assert that the free care beneficiaries are medicare recipients and that their costs are reimbursable as such. Rather, plaintiff argues that the costs of free care are incidental allowable costs, similar

> in nature to interest or depreciation, neither of which go directly to benefit medicare patients, but which nonetheless inure as a residual benefit to them and are thus compensable on that basis. Consequently, defendant's response functions in a misplaced context.

435 F.Supp. at 388.

Like the plaintiff in *Rapides*, the Hospital does not deny that indigent patients directly benefited from its free care expenses. It argues, instead, that those expenses are *indirect* costs incurred for the benefit of all of the patients of the Hospital. We note that both the statute and the regulations provide for reimbursement for indirect as well as direct costs. 42 U.S.C. § 1395x(v)(1)(A); 42 C.F.R. § 405.451(c)(3) (1979). Indeed, the regulations allow reimbursement for a number of specific indirect costs, including depreciation, interest, some types of bad debts, research costs, and even a return on the equity capital of proprietary owners. *See* 42 C.F.R. § 405.401 *et seq.* (1979). In particular, an interest payment actually made by the Hospital to a lender of funds is clearly reimbursable, 42 C.F.R. § 405.419(b) (1979), and the Hospital was in fact reimbursed for that portion of the interest on its outstanding loans which was paid by the Hospital rather than by the government pursuant to the Hill-Burton Act. Although free care expenses are not "interest" within the meaning of the regulations, *see id.*, we are unable to distinguish such expenses in principle from interest and other indirect costs. It is undisputed that the Hospital was legally obligated to make such expenses, and it is also undisputed that the expenses indirectly benefited medicare patients by qualifying the Hospital for interest subsidies on construction and modernization projects. The fact that such expenses also benefited indigent persons who were not medicare beneficiaries is irrelevant to the determinative issue: whether the expenses were reasonable cost incurred in the provision of services to medicare patients. We conclude, therefore, that the free care expenses incurred by the Hospital in connection with its obligations under the Hill-

Burton Act were reasonable costs of providing care to medicare patients and are consequently reimbursable.[3]

In addition to its explicit reliance on the principle that medicare should not pay for costs that were not incurred in the provision of services to medicare patients, the Board quotes the language of 42 C.F.R. § 405.420(c) (1979), which provides:

> Normal accounting treatment: reduction in revenue. Bad debts, charity, and courtesy allowances represent reductions in revenue. The failure to collect charges for services rendered does not add to the cost of providing the services. Such costs have already been incurred in the production of the services.

This provision in effect bars a medicare provider from collecting twice for the same reimbursable cost: once for the expenses incurred in the provision of medical services and once for the provider's failure to receive payment for those services. Thus, if the Hospital has already been reimbursed by the Intermediary for the costs incurred in providing free care to indigents, it may not also be reimbursed for the reduction in revenue caused by the inability of the indigent recipients of those services to pay for their care.

However, the factual issue raised by this regulation does not appear to have been addressed by any of the parties or to have been considered by the Board. Neither the Interme-

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[3]On appeal, the government also contends that reimbursement of free care expenses gives the Hospital a windfall; since the interest subsidy received by the Hospital is greater than its free care expenses, so the government argues, the Hill-Burton Act gives the Hospital a net gain rather than a loss. It is true that the Hill-Burton Act saves the Hospital money, but it does so by reducing its expenses and not by increasing its revenue; accordingly, the Hospital now seeks reimbursement only for the lower cost of borrowing funds (*i.e.*, interest payments plus free care expenses), and does not seek reimbursement for the higher interest expenses it would incur in the absence of the Hill-Burton Act.

diary (in its presentation to the Board) nor the government (in its brief on appeal) made an argument based on this provision of the regulations; both relied instead on the first argument dealt with in this opinion, that is, that the free care costs directly benefited the indigent recipients of the care rather than medicare patients.[4] Moreover, the Board does not address this question in its opinion. The Board's quotation of section 405.420(c) of the regulations is in fact followed by its explanation of the argument with which we have already dealt; the Board at no point states that free care expenses have twice been included in the Hospital's calculation of allowable costs, and makes no attempt to explain why this bar on "double counting" is at all relevant to the facts of this case.[5] In fact, the Board does not appear

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[4]Nor does it appear that the district court considered this question. Although the district court's brief memorandum opinion also cites section 405.420 of the regulations, it refers to no finding that free care expenses have already been reimbursed, and relies on that section only for the unrelated principle with which we have already dealt, in particular, that "charity allowances have no relationship to beneficiaries of the medicare program and are [therefore] not allowable costs."

[5]The Board's entire explanation of its decision on the free care expense issue is as follows:

> The Board does not dispute the Provider's legal responsibility to provide free care pursuant to Hill-Burton requirements nor the value the interest subsidy has in relationship to enabling the Provider to render improved health care services. However, the cost which the Provider is seeking with respect to the associated free care must be put in its proper perspective. The Board finds that the cost of free care is explicitly dealt with in the Regulations. More specifically, 42 CFR 405.420(c) states: [the section is quoted in full] Accordingly, the failure to collect for the free care does not convert the charge into a reimbursable cost. Although the Board recognizes that the cost of rendering the free care is a cost to the facility, the Regulations specifically exclude charity allowances from allowable cost. An allowance for the free care would be in direct opposition to the objective of determining reasonable cost whereby costs with respect to individuals covered by the program will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by the program. The

to have considered the precise amount of the Hospital's free care expenses.[8] This is understandable, since the Board disallowed reimbursement; still it is difficult to imagine how the Board could find that the Hospital had already been reimbursed for those expenses without first deciding what the expenses were. It would appear, therefore, that the Board's decision may rest solely on the principle that medicare should not pay costs attributable to the care of non-medicare patients, and not at all on the rationale underlying section 405.420(c). Certainly there is no indication that the Board has considered the factual question raised by section 405.420(c).

Two factual issues therefore remain to be resolved before the Hospital can be reimbursed for its free care expenses: whether or to what extent the Hospital has already been reimbursed for those expenses in the fiscal year at issue, and, to the extent that the Hospital's free care expenses have not been reimbursed, precisely what those expenses are. As we explained above, the Hospital is entitled to reimbursement for the medicare patients' portion of expenses incurred as a result of obligations assumed under the Hill-Burton Act, provided that those expenses have not already been included in the Hospital's reimbursed costs.

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patients in this case who are receiving the disputed free care fall into the latter category of patients. Inasmuch as they are not Medicare beneficiaries, their costs, the free care, may not be borne by the program.

*Presbyterian Hospital of Dallas v. Blue Cross Association Group Hospital Service, Inc.*, Provider Reimbursement Review Board Decision No. 78-96, at 13 (Feb. 28, 1979).

[8]The Hospital introduced the testimony of Marshall Chamness, Jr., the Hospital's financial director, to explain the basis of the Hospital's claim for reimbursement of its free care expenses. He explained on cross-examination that the $178,871 free care figure was based on "normal charges" rather than on "actual costs," and admitted that the "cost" of providing the free care was probably about $158,700. Record at 176-77. No other testimony was presented on this question, and the Board does not appear to have examined the accuracy of Chamness' estimate.

[4, 5] Although factual issues remain to be resolved, however, these questions may not be decided *de novo* by the district court. *De novo* determination of a factual question in a judicial review of an adjudicatory proceeding governed by the Administrative Procedure Act is authorized only if the agency factfinding procedures are inadequate. *Camp v. Pitts*, 411 U.S. 138, 141-42, 93 S.Ct. 1241, 1243, 36 L.Ed.2d 106 (1973); *Citizens to Preserve Overton Park v. Volpe*, 401 U.S. 402, 415, 91 S.Ct. 814, 823, 28 L.Ed.2d 136 (1971). Otherwise the courts must allow the agency to decide the issue for itself. Where an error of law has been corrected by a reviewing court, and the only issues remaining in the case are questions which have not yet been considered by the administrative agency but are nevertheless within the agency's authority, the appropriate action is a remand to the agency so that it may exercise its authority. As the Supreme Court explained in *FPC v. Idaho Power Co.*, 344 U.S. 17, 20, 73 S.Ct. 85, 86, 97 L.Ed 15 (1952), "the guiding principle . . . is that the function of the reviewing court ends when an error of law is laid bare. At that point the matter once more goes to the Commission for reconsideration." *See, e.g., South Prairie Construction Co. v. Local No. 627, International Union of Operating Engineers*, 425 U.S. 800, 806, 96 S.Ct. 1842, 1845, 48 L.Ed.2d 382 (1976); *NLRB v. Food Store Employees*, 417 U.S. 1, 9, 94 S.Ct. 2074, 2079, 40 L.Ed.2d 612 (1974); *FCC v. Pottsville Broadcasting Co.*, 309 U.S. 134, 145, 60 S.Ct. 437, 442, 84 L.Ed. 656 (1940); *Whittaker Corp. v. United States*, 443 F.2d 1373, 1386 (Ct.Cl.1971); *McBride v. Smith*, 405 F.2d 1057, 1059 (2d Cir. 1968); *Citizens Band of Potawatomi Indians v. United States*, 391 F.2d 614, 624 (Ct.Cl.1967), *cert. denied*, 389 U.S. 1046, 88 S.Ct. 771, 19 L.Ed.2d 839 (1968). Since there is no suggestion that there is any inadequacy in the Board's fact finding procedures, this case should be remanded to the Board for proceedings consistent with this opinion.

## IV. CONCLUSION

Medicare patients do not have a First Amendment right to the inclusion of the costs of television and telephone ser-

vice in medicare coverage; we therefore affirm the district court's summary judgment in favor of the Secretary with respect to television and telephone expenses. Free care expenses for which the Hospital becomes obligated under the Hill-Burton Act are, however, included as a matter of law within a medicare provider's reasonable expenses under the Social Security Act; we therefore reverse the district court's summary judgment in favor of the Secretary with respect to the free care expenses. Since the Hospital's claim rests on factual issues which were not reached by the Board, we direct the district court to remand this case to the Secretary for proceedings consistent with this opinion.

AFFIRMED IN PART and REVERSED IN PART with DIRECTIONS TO REMAND.

**UNITED STATES COURT OF APPEALS**

**For the Fifth Circuit**

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**No. 80-1589**
**Summary Calendar**

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D. C. Docket No. CA 3 79 0529 D
PRESBYTERIAN HOSPITAL OF DALLAS,
*Plaintiff-Appellant,*

*v.*

PATRICIA R. HARRIS, *Secretary of Health and Human Services,*
*Defendant-Appellee.*

***Appeal from the United States District Court for the***

**NORTHERN DISTRICT OF TEXAS**

Before GEE, RUBIN and RANDALL, Circuit Judges.

**JUDGMENT**

This cause came on to be heard on the transcript of the record from the United States District Court for the Northern District of Texas, and was taken under submission by the Court upon the record and briefs on file, pursuant to Rule 18;

ON CONSIDERATION WHEREOF, It is now here ordered and adjudged by this Court that the judgment of the said District Court in this cause be, and the same is hereby, affirmed in part and reversed in part with directions to remand this cause to the Secretary for proceedings consistent with the opinion of this Court;

It is further ordered that each party bear their own costs on appeal in this Court.

March 13, 1981

Issued as Mandate:

**IN THE**
**UNITED STATES COURT OF APPEALS**
**FOR THE FIFTH CIRCUIT**
**Unit A**

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**No. 80-1589**

U. S. Court of Appeals
RECEIVED
APR 2 1981
New Orleans, LA.
U. S. Court of Appeals
FILED
APR 2 1981
Gilbert F. Ganucheau
Clerk

PRESBYTERIAN HOSPITAL OF DALLAS,

*Plaintiff-Appellant,*

*versus*

PATRICIA R. HARRIS, Secretary of Health and Human Services,

*Defendant-Appellee.*

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**Appeal from the United States District Court for the Northern District of Texas**

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**Order:**

IT IS ORDERED that the motions of the parties for an extension of time to and including April 27, 1981, within which to file petition for rehearing and petition for rehearing en banc, is granted.

CAROLYN DURIEN RANDALL
United States Circuit Judge

**IN THE UNITED STATES COURT OF APPEALS**
**FOR THE FIFTH CIRCUIT**
**UNIT A**

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**No. 80-1589**

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PRESBYTERIAN HOSPITAL OF DALLAS,

*Plaintiff-Appellant,*

*v.*

PATRICIA R. HARRIS, *Secretary of Health and Human Services,*

*Defendant-Appellee.*

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***Appeal from the United States District Court for the***

**NORTHERN DISTRICT OF TEXAS**

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**ON PETITIONS FOR REHEARING AND PETITIONS FOR REHEARING EN BANC**

(Opinion March 13, 1981, 5 Cir., 198..., ..... F.2d.....).
(May 11, 1981)

Before GEE, RUBIN and RANDALL, Circuit Judges.

PER CURIAM:

(X) The Petitions for Rehearing are DENIED and no member of this panel nor Judge of this Administrative Unit in regular active service having requested that the Court be polled on rehearing en banc (Rule 35, Federal Rules of Appellate Procedure; Local Fifth Circuit Rule 16; Fifth Circuit Judicial Council Resolution of January 14, 1981), the suggestions for Rehearing En Banc are DENIED.

In The

# United States District Court

FOR THE NORTHERN DISTRICT OF TEXAS
DALLAS DIVISION

CIVIL ACTION NO. CA-3-79-0529-D

PRESBYTERIAN HOSPITAL OF DALLAS,

*Plaintiff,*

*v.*

PATRICIA ROBERTS HARRIS,
Secretary of Health, Education and Welfare
of the United States of America,

*Defendant.*

## JUDGMENT

Came on for consideration before the court, the Honorable Robert M. Hill, District Judge, presiding, the motion for summary judgment of the defendant Patricia Roberts Harris and the court having granted the defendant's motion,

It is ORDERED and ADJUDGED that the plaintiff, Presbyterian Hospital of Dallas, take nothing against the defendant, that the plaintiff's claims against the defendant be dismissed on the merits and with prejudice, and that the defendant recover her costs of action from the plaintiff.

Dated this 28th day of March, 1980.

Robert Hill
United States District Judge

In The

# United States District Court

FOR THE NORTHERN DISTRICT OF TEXAS
DALLAS DIVISION

CIVIL ACTION NO. CA-3-79-0529-D

PRESBYTERIAN HOSPITAL OF DALLAS,
*Plaintiff,*

*v.*

PATRICIA ROBERTS HARRIS,
Secretary of Health, Education and Welfare
of the United States of America,
*Defendant.*

## ORDER

Came on for consideration before the court the motion for summary judgment of defendant Patricia Roberts Harris ("defendant"). The court, having reviewed the motion and the briefs submitted by the parties and having heard the arguments of the parties, is of the opinion that the defendant's motion for summary judgment should be granted.

In this action plaintiff Presbyterian Hospital of Dallas ("plaintiff"), a qualified provider of services under the Medicare provisions of the Social Security Act, 42 U.S.C. § 1395-1395rr (1974 and Supp. 1979) (the "Act"), challenges the defendant's final decision that the plaintiff should not be reimbursed for certain costs which it incurred during its 1975-1976 fiscal year. The plaintiff initially sought judicial review of the defendant's determination that some or all of four expenses which the plaintiff incurred, the expense of providing free care to indigents pursuant to the plaintiff's obligation under the Hill-Burton interest subsidy program, 42 U.S.C. § 291j-1(a)(1) *et seq.* (1974), the expense of

interest paid during the construction of a subacute facility, Presbyterian West, the expense of providing patients with telephones in their rooms, and the expense of providing patients with televisions in their rooms, were not reimbursable under the Act. However, in its memorandum of law and reply to defendant's motion for summary judgment the plaintiff abandoned its challenge to the defendant's disallowance of the interest expense which the plaintiff incurred during construction. *See Good Samaritan Hospital v. Mathews*, 609 F.2d 949 F.2d (9th Cir. 1979). Accordingly, the Court will address the defendant's motion for summary judgment only in connection with the plaintiff's claims concerning reimbursement for the costs of indigent care, in-room telephones, and in-room televisions.

The Court has reviewed the administrative record and is of the opinion that the defendant's disallowance of costs which the plaintiff incurred in providing care to indigents under the Hill-Burton interest subsidy program and in-room telephones and televisions is supported by substantial evidence. The defendant acted neither arbitrarily nor capriciously in disallowing these costs for which the plaintiff seeks reimbursement: the Act and the pertinent regulations fully support the defendant's decision. *See* 42 C.F.R. § 405, 420 (1979) (charity allowances have no relationship to beneficiaries of the Medicare program and are not allowable costs); *see also*, 42 U.S.C. § 1395y(a) (6) (1974) (reimbursement improper for personal comfort items); 42 C.F.R. 405.310j(1979) (telephones and television sets are personal comfort items); *St. Francis Hospital v. Califano*, 479 F.Supp. 761, 764 (D.D.C. 1979) (telephones constitute personal comfort items).

The plaintiff has raised no genuine issue of material fact which renders summary judgment inappropriate.[1] Accord-

[1]The Court wholeheartedly rejects the plaintiff's "constitutional" argument concerning the abridgment of its patients' rights to freedom of speech and to freedom of communication. The authorities which plaintiff cites are inapposite and the analogy between hospital patients and prisoners is both ill-conceived and ill-fated.

ingly, the defendant's motion for summary judgment should be granted.

It is so ORDERED.

Dated this 28th day of March, 1980.

ROBERT HILL
United States District Judge

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Health Care Financing Administration
Baltimore Maryland 21235
April 25, 1979

Refer to: IOA/OAA

Office of Attorney-Advisor
G-50 Altmeyer Building
(301) 594-5132

Grover Hartt, Jr., Esq.
Hartt and Hartt
Attorneys and Counselors
12700 Park Central Place, Suite 1610
Dallas, Texas 75251

Dear Mr. Hartt:

Re: *Presbyterian Hospital of Dallas v. Blue Cross Association/Group Hospital Service, Inc.*, Determination of Reasonable Costs for Cost Reporting Period Ending September 30, 1976, PRRB Decision No. 79-D9 dated February 28, 1979

This is to advise that the Administrator of the Health Care Financing Administration, to whom the Secretary of Health, Education, and Welfare has delegated the responsibility for administration of the Medicare Act, has declined to reverse, affirm, or modifv, on his own motion, the decision

entered by the Provider Reimbursement Review Board in the captioned case.

If the Provider wishes to obtain judicial review of the matter, civil action must be initiated within 60 days of the date the Administrator's decision is received. For your ready reference, I enclose a copy of Section 1878(f) of the Social Security Act, as amended [42 USC 1395oo(f)].

Sincerely yours,

Erica L. Gosnell, Director
Office of Attorney-Advisor

Enclosure

**PROVIDER REIMBURSEMENT REVIEW BOARD**
**HEARING DECISION**

**79-D 9**

PROVIDER — PRESBYTERIAN HOSPITAL OF DALLAS,
Dallas, Texas

*vs.*

INTERMEDIARY — BLUE CROSS ASSOCIATION
GROUP HOSPITAL SERVICE, INC.

Date of Hearing: September 19, 1978

Cost Reporting Period Ending September 30, 1976

**CASE NO. 78-96**

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## ISSUES

1. Whether or not the expense of free care required under a Hill-Burton interest subsidy is an allowable cost?
2. Whether or not interest during construction is an allowable current cost?
3. a) To what extent is the Provider's telephone expense an allowable cost?

   b) To what extent is the Provider's television expense an allowable cost?

## STATEMENT OF FACTS

The Provider is a 508-bed, acute care hospital. A cost report for the year ending September 30, 1976, was filed with the Provider's fiscal Intermediary.

**Issue No. 1 — Hill-Burton Interest Subsidy**

During the period under appeal, the Provider received an interest subsidy for four loans through the Hill-Burton program. The loans are more fully described as follows:

(1) $3,000,000 Second Mortgage Bonds for construction of additional and modernization of existing hospital facilities; Lender: Western & Southern Life Insurance Company, Cincinnati, Ohio; Trustee: Republic National Bank, Dallas, Texas; December 1, 1972. Total interest for fiscal 1976: $225,335; Interest subsidy portion: $87,230. Project No.: 06-C-48-055-0-00-0.

(2) $900,000 Third Mortgage Bonds for construction of additional and modernization of existing hospital facilities; Lender: Iowa Public Employees Trust Fund; Trustee: Republic National Bank, Dallas, Texas; December 1, 1972. Total interest for fiscal 1976: $67,533; Interest subsidy portion: $26,142. Project No.: 06-C-48-055-0-00-0.

(3) $418,697 Fourth Mortgage Loan for expansion of existing hospital facilities and 27 new beds; Lender: Teacher Retirement System of Texas; October 31, 1973. Total interest for fiscal 1976: $32,477.19; Interest subsidy portion: $12,255.54. Project No. 06-C-48-055-0-00-0.

(4) $6,222,210 First Mortgage Loan for construction of a sub-acute hospital facility — Presbyterian West; Lender: Teacher Retirement System of Texas; January 25, 1975. Total interest for fiscal 1976: $279,093.56; Interest subsidy portion: $99,579.49. Project No.: 06-C-48-089-0-00-1.

The total amount of Hill-Burton interest subsidy for these loans during the period ending September 30, 1976, was

$225,207.03. As a condition for participation in a Hill-Burton program, a provider must render free care to the indigent in accordance with one of three prescribed methods. A provider's free care obligation is met by:

(1) Providing an amount of free care equal to three percent (3%) of its operating cost; or

(2) Providing an amount of free care equal to ten percent (10%) of the total of all federal assistance received; or,

(3) Providing free care to all of those unable to pay who present themselves for care on an "open door basis".

The Provider is generally obligated to provide this free care for 20 years.

In this case, the Provider opted to satisfy its free care obligation through the "open door" policy. The Provider determined that during the period under appeal free care totaling $178,871 in charges was rendered pursuant to its "open door" policy. Accordingly, the Provider has sought reimbursement for the cost of the free care. The Intermediary has taken exception to the allowability of this cost.

**Issue No. 2 — Interest During Construction**

In December, 1974, Presbyterian began construction of a sub-acute facility, "Presbyterian West," located adjacent to its main hospital building. To finance the construction project, Presbyterian executed a Deed of Trust Note with Teacher Retirement System of Texas in the principal sum of $6,222,210 with interest payable at the rate of 8.4 percent annum.

From its inception, Presbyterian has always followed the generally accepted accounting policy of expensing all interest costs, including all interest paid during periods of construction. In the first year of construction of the sub-acute facility, Presbyterian paid approximately $28,624 in interest expense pursuant to the "Teachers Loan." In its cost report

for the period ending September 30, 1975, Presbyterian included this interest expense as an allowable cost and sought reimbursement from the fiscal Intermediary. The Intermediary disallowed this cost by an audit adjustment. Presbyterian in its Statement of Acceptance dated September 28, 1976, noted its disagreement with the Intermediary's decision to disallow the cost of interest expense paid during construction.

In its fiscal year ended September 30, 1976, Presbyterian again followed the generally accepted hospital accounting and reporting practice of expensing interest paid during periods of construction. This accounting procedure was approved by Presbyterian's certified public accountants. Realizing that the Intermediary would again disallow this expense and believing that Presbyterian might be subject to fraud and abuse penalties for failure to follow prior determinations of the Intermediary, Presbyterian showed this interest expense as an adjusting item on its cost report for the period ending September 30, 1976. The Intermediary in its Notice of Program Reimbursement dated September 30, 1977, made the determination that the construction period interest was not an allowable cost and eliminated the sum of $179,514 from allowable costs by its audit adjustment #50. The Provider takes exception to this adjustment.

**Issue No. 3 — Telephone and Television Costs**

Presbyterian provides a telephone and television to all patients without an additional charge. In a semi-private room, the patients share the use of a television and telephone. During the period under appeal, the Provider incurred the following telephone costs:

| | |
|---|---|
| Switchboard Salaries | $ 99,368 |
| Switchboard Equipment Costs | 60,881 |
| Telephone Jack Costs | 61,349 |
| | $221,598 |

The Intermediary has determined that 34.72 percent of these costs are non-allowable costs. The 34.72 percent rep-

resents the ratio of patient telephone jack costs to the number of telephone jack costs in the Provider's facility.

The Provider incurred television rental and repair expenses of $6,062 during the period at issue in this appeal. In addition, depreciation of $2,657 for the television equipment was charged to allowable costs by the Provider.

Subsequently, the Intermediary determined that 100 percent of the television costs were non-allowable costs. The Provider takes exception to this finding.

The Intermediary issued a Notice of Program Reimbursement to the Provider for the cost reporting period ending September 30, 1976 on September 30, 1977. On March 27, 1978, the Provider filed a timely Request for a hearing. A hearing was held on September 19, 1978.

## CITATION OF APPLICABLE LAW, REGULATIONS, AND PROGRAM INSTRUCTIONS

Appendix

**I. Regulations 42 CFR 405, Regulations No. 5, Subpart A & D**

1. § 405.310(j) — Types of expenses not covered — A
2. § 405.419 — Interest Expense — B
3. § 405.420 — Bad Debts, Charity and Courtesy Allowances — C
4. § 405.451 — Cost Related to Patient Care — D

**II. Program Instructions**

*Provider Reimbursement Manual, Part I, (HIM-15)*

1. § 206 — Interest During Period of Construction — E
2. § 328 — Charity, Courtesy, and Third-Party Payer Allowances — F
3. § 2106 — Cost of Telephone, Television and Radio — G

## CONTENTIONS OF THE PARTIES

**Issue No. 1 — Hill-Burton Interest Subsidy**

*Provider*

The Provider asserts that the costs of its aforementioned loans are evidenced by the interest that is paid and the cost of the free care that is required to be rendered. The Intermediary has not challenged the interest paid by the Provider as not necessary and proper on the borrowed funds. Accordingly, it should follow that the cost of free care which the Provider is legally bound to provide to indigents is just as much a cost as is interest payments. The interest subsidy is not a free gift. In exchange for the Government's assistance with interest payments, the Provider became legally bound to assist the Government by providing free care to indigents that the Government might otherwise have been required to provide.

Refusal to allow the free care cost would result in non-Medicare patients paying for the benefits which the Medicare patients receive. The benefits that the Medicare patient receives from the rendering of free care by the Provider is measured by an improved and expanded facility which the Medicare patient would not have otherwise enjoyed. Thus, requiring non-Medicare patients to bear the entire free care cost is contrary to Medicare statutory provisions, wherein the total institutional cost that is borne by the program is related to the care furnished beneficiaries so that no part of their cost would need to be borne by other patients. The free care obligation imposed by the Hill-Burton program is deemed by the Provider to be an institutional cost which by statute must be shared by Medicare and non-Medicare patients.

In a similar case, *Rapides General Hospital v. Matthews*, 435 F. Supp. 384 (W. D. La. 1977), it is noted by the Provider that the Court recognized that the free care expense was a cost necessary for financing new construction which would benefit both Medicare and non-Medicare patients.

Accordingly, the Court held the cost to be reimbursable. Similarly, the Provider argues that it should be afforded the same treatment.

*Intermediary*

The Intermediary contends that the cost of free patient care cannot be considered a program cost. The free care required to be rendered by the Provider bears no relationship to the costs which are related to Medicare beneficiaries. To further support its position, the Intermediary cites Decision 76-D3 of the Provider Reimbursement Review Board, wherein the Board found that:

> "The Provider is not entitled to include in cost the interest subsidy by Hill-Burton nor the cost of free care which the Provider was legally obligated to perform as a condition precedent for obtaining a Hill-Burton interest subsidy."

**Issue No. 2 — Interest During Construction**

*Provider*

The Provider asserts that interest incurred during construction is an allowable cost. Regulation 405.419 allows both long term and short term interest as an allowable cost. There is no ambiguity in this section as to interest being an allowable cost. The interest payment made by Presbyterian was an indirect cost for developing a patient care facility which would benefit all patients and as such is clearly within the scope of Regulation Sections 405.419 and 405.451, notwithstanding the program's instructions to the contrary, namely § 206 of HIM-15-1. The Provider argues that its interest cost meets the Regulations' definition of necessary and proper costs:

> "Necessary and proper costs are costs which are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities." (§ 405.451 (b) (2))

The Provider also contends that 42 CFR 405.406(a) supports its method of expensing interest during construction. This Section does not mandate any particular method of accounting or cost finding, but states that widely accepted practices will be allowed. In addition, § 405.406(a) states that providers will not be required to change practices in order to determine costs payable under the principles of reimbursement. The clear wording of this Regulation allows Presbyterian to continue using its widely accepted accounting practice of expensing interest during construction to determine the costs specifically reimbursable under the Medicare Act. In further support of expensing interest during construction, the Provider introduced into evidence expert testimony given by Dr. Herbert Miller in the Provider Reimbursement Review Board case of *Portland Adventist Medical Center, Portland Oregon v. Blue Cross Association, Blue Cross of Oregon*, Decision No. 78-D58. Dr. Miller in the aforementioned case testified that interest is a financing cost, not a cost of construction. The expensing of interest in its financial reports has been practiced consistently from the construction of the original facility and as such should be allowed as a current cost in accordance with generally accepted accounting principles. The expensing of interest during construction is further supported by the following authorities:

(1) Welsch, Glen A., Ph.D., C.P.A.; Zlatkovich, Charles T., Ph. D., C.P.A.; White, John Arch, Ph. D.; *Intermediary Accounting*, Revised Edition, Homewood, Illinois: Richard D. Irwin, Inc. (1968), Page 372.

"Interest is a cost of borrowing funds rather than a cost of the asset acquired with those funds. Therefore, capitalization of interest during the construction period is not theoretically sound from an accounting point of view and should not be permitted."

(2) American Institute of Certified Public Accountants, *AICPA Professional Standards*, Volume 3 (1977), Sections 1026.23 & 1026.24.

"The cost of an asset that provides benefits for only one period is recognized as an expense of that period.

"Some costs are associated with the current accounting period as expenses because costs incurred during the period provide no discernible future benefits."

(3) AICPA Industry Accounting Guide, "Accounting for Motion Picture Films" (page 14)

"Interest on funds borrowed and expended for film production has in some instances been capitalized as a production cost. The Committee has concluded that it is not appropriate to capitalize interest as a production cost; interest costs are properly treated as a period expense."

(4) National Association of Accountants, *Statement on Management Accounting Practices by the N.A.A.*: STMT #4 — *Fixed Asset Accounting: The Capitalization of Costs* (October 20, 1972)

Interest on long-term debt does not add value to the fixed asset being purchased and should not be capitalized."

"When purchasing capital assets, the price being paid for the capital assets must be separated from the price being paid for the use of funds. The price paid for the use of funds (interest) should not be capitalized.

"Interest during the period of construction should not be capitalized except in the utility and real estate industries where the current acceptance of this practice and the economics of these industries permit such capitalization.

(5) Interagency Regulatory Accountants Committee, "Accounting for Interest During Construction," February, 1976, position paper.

"Assets on the balance sheet represent productive resources of 'real capital,' instead of 'money capital'. Interest is paid to acquire the use of money capital which in turn is used to acquire assets. Thus, interest is not an increment to assets.

"Interest in essence is a periodic expense. It is a cost of using capital for one period of time and it expires with the lapse of the period. Continued use of the capital in the next period will incur new interest. Thus, interest is associated with periods, rather than revenue generating activities.

"Interest should be recognized as an expense in the period in which it is paid or accrued."

Accordingly, being required to recover the interest cost over 40 years is clearly contrary to the Regulations. Section 206 of HIM-15-1 tells the Provider that generally accepted accounting principles will be followed where beneficial to the Medicare Program. If not beneficial, the Program will change the practice. Under the Intermediary's interpretation of the issue in dispute, the Provider argues that under the present value concept it will be reimbursed less than 20 percent of the value of the dollars actually spent. This present value concept was also argued by an expert witness in the Portland Adventist case. The Provider asserts that the testimony of this witness, Dr. Intriligator, is equally applicable to the facts in this case.

Finally, the Provider argues that § 206 of HIM-15-1 was not promulgated pursuant to the rule making procedures of the Administrative Procedure Act (5 USC 501 et. seq.). The Administrative Procedure Act requires that notice of a rule proposed by a Federal Agency be published in the Federal Register. This was not done in the case of § 206.

*Intermediary*

The Intermediary asserts that § 206 of HIM-15-1 specifically states that interest costs incurred during the period of construction must be capitalized to the cost of the facility. The period of construction is considered to extend to the date the facility is put into use for patient care. This manual section has its basis in the general Medicare regulation § 405.451 which states that only costs related to patient care are allowable. During a period of construction

the facility or portion of a facility being constructed is clearly not being used for patient care purposes, and the interest costs associated with the financing during the construction period are, therefore, not costs related to patient care. It should be noted that capitalized interest becomes a part of the basis of the property, and that when and if the property is placed in use for patient care purposes depreciation is an allowable cost of which the Medicare program pays its proportionate share. Thus, the Medicare program will ultimately recognize and share in the cost in question if, in fact, the constructed items are used for patient care purposes.

The Intermediary further argues that in Portland Adventist, the majority of the Provider Reimbursement Review Board held that interest during construction must be capitalized not withstanding expert testimony from a well-known accounting educator and author, Dr. Herbert Miller and a recognized economist, Dr. Intriligator, both of whom testified to the contrary.

**Issue No. 3 — Telephone and Television Costs**

*Provider*

The Provider contends that the Intermediary's determination that telephones and televisions are luxury items furnished solely for the personal comfort of the patient was in error. Reimbursement under the Medicare program is based upon concepts of reasonable charges for the necessary costs incurred in efficiently delivering the needed health services to Medicare patients. The Intermediary has erroneously determined that the telephone and television services have been provided strictly for the comfort of the patient and are not costs related to patient care. This determination ignores the indirect uses of patient telephones and televisions, as well as the direct therapeutic value that these items have.

The Medicare Act itself recognizes the value of therapeutic services by defining "inpatient hospital services" to

include such therapeutic items or services as are ordinarily furnished to inpatients by the hospital (42 U.S.C. § 1395x-(b)(3)). Doctors and nurses who observe patients in a hospital environment on a daily basis recognize the direct medical benefits of providing telephone and television service to patients.

The recovery of a patient is enhanced by having access to instruments of communication which allow a patient to remain in personal contact with family, friends, and business interests. This access to communication relieves the anxieties which would be created if the patient were isolated from the outside world. Doctors continually stress that the mental well-being of patients makes a significant and positive contribution to physical well-being and ultimate recovery.

The therapeutic benefits of telephones and televisions have been specifically noted by the medical staff in Presbyterian's intensive care units. Doctors initially felt that the removal of televisions in the intensive care rooms might create a calmer atmosphere more conducive to recovery. However, after a relatively short period, the medical staff determined that the condition of the patients in the intensive care units was not adversely affected by television and that the presence of television was in fact beneficial. The televisions were reinstalled. Further, there is no reason why this conclusion does not apply equally well to all hospital patients.

Similarly, a telephone in the patient's room provides its own distinct direct and indirect health care benefits to the patient and the hospital. The Provider Reimbursement Review Board has acknowledged in previous decisions that a telephone may be used for the following patient care related cases:

(a) cardiac arrest notification;

(b) emergency need for physician notification;

(c) physican-hospital staff notification;

(d) patient-physician office communication;

(e) patient-condition monitoring;

(f) patient-government program communication;

(g) patient-discharge arrangements;

(h) patient-hospital administration communication;

(i) patient-condition inquiry; and

(j) patient-nurse communication.

In addition, the telephone may be used by patients for indirect health care purposes in that the patient is able to communicate regarding items directly related to the patient's stay in the hospital, such as:

(a) discuss discharge date;

(b) arrange transportation;

(c) request items to be brought to the hospital;

(d) arrange for medical equipment, supplies, and care after discharge;

(e) discuss dietary needs;

(f) relieve anxiety and concern regarding family arrangements of children's care and direction;

(g) express needs and complaints to hospital administration staff;

(h) discuss condition with family members and friends, so as to control the flow of visitors;

(i) discuss insurance arrangements and accounts with business office;

(j) call physician office to discuss care; and

(k) seek assistance from others to translate and communicate care problems and needs to physician and hospital staff who may not speak the same language.

The Intermediary has relied on Section 2106.1 of HIM-15-1 to disallow the "full costs of items or services such as telephone, television, and radio which are located in patient accommodations and which are furnished solely for the personal comfort of patients." The potential uses of the telephone and television enumerated above would clearly indicate that these services are not furnished *solely* for the personal comfort of the patient, but instead provide actual medical benefits. This erroneous conclusion by the Intermediary resulted in its mistaken application of Section 2106.1 of HIM-15-1.

The Intermediary's determination also implies that these services are luxury items which the program should not be required to pay. However, the Medicare program manual defines luxury items or services as "those that are substantially in excess of or more expensive than the usual items or services rendered within a provider's operation to the majority of patients." Section 2104.3 of HIM-15-1. Presbyterian has always provided telephone and television service to *all* patients, believing these items to be medically beneficial and a necessity of modern life. Thus, even under the restrictive interpretations of HIM-15-1, these services would not be considered luxury services.

*Intermediary*

The Intermediary asserts that the Medicare program will reimburse for services which are reasonable and necessary for the diagnosis and treatment of illness or injury. Regulations 405.310(j) specifically states that no payment will be made for "personal comfort items and services (for example, a television set, or telephone service, etc.)." Additional support of identifying telephone and television services as personal comfort items can be found in the Congressional Committee Reports preceding the enactment of Title XVIII. Accordingly, the Intermediary finds that it has no alternative but to disallow the direct and indirect costs relative to patient telephones and televisions.

## CONCLUSIONS AND FINDINGS

The Provider Reimbursement Review Board, after consideration of the facts, the parties' contentions, and evidence presented, concludes and finds:

**Issue No. 1 — Hill-Burton Interest Subsidy**

The Board does not dispute the Provider's legal responsibility to provide free care pursuant to Hill-Burton requirements nor the value the interest subsidy has in relationship to enabling the Provider to render improved health care services. However, the cost which the Provider is seeking with respect to the associated free care must be put in its proper perspective. The Board finds that the cost of free care is explicitly dealt with in the Regulations. More specifically, 42 CFR 405.420(c) states:

> (c) Normal accounting treatment: reduction in revenue. Bad debts, charity, and courtesy allowances represent reductions in revenue. The failure to collect charges for services rendered does not add to the cost of providing the service. Such costs have already been incurred in the production of the services.

Accordingly, the failure to collect for the free care does not convert the charge into a reimbursable cost. Although the Board recognizes that the cost of rendering the free care is a cost to the facility, the Regulations specifically exclude charity allowances from allowable cost. An allowance for the free care would be in direct opposition to the objective of determining reasonable cost whereby costs with respect to individuals covered by the program will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by the program. The patients in this case who are receiving the disputed free care fall into the latter category of patients. Inasmuch as they are not Medicare beneficiaries, their costs, the free care, may not be borne by the program.

**Issue No. 2 — Interest During Construction**

The allowability of the interest cost is not being disputed in this case. The issue in dispute is the timing of the reimbursement for the interest. The Board finds that the authority for capitalizing interest during construction to be found in § 405.451 of the Regulations.

> "405.451 Cost related to patient care
>
> (a) Principle. All payments to providers of services must be based on the reasonable cost of services covered under Title XVIII of the Act and *related to the care of beneficiaries.*" (Emphasis added)

Although this section does not explicitly treat the subject matter in this case, it implicitly requires that costs be related to the care of beneficiaries. It is an undisputed fact in this case that the interest incurred was not directly related to the current care of patients, inasmuch as the facility being built did not benefit patients until 1977. The Board finds that § 405.451 takes precedence over all other principles of reimbursement, in that costs must be reasonable and *related to care of beneficiaries.* The Provider has not shown that the cost is currently related to patient care.

Although the evidence presented at the hearing strongly indicates that it has become a generally accepted accounting principle to treat interest during construction in progress as a current period cost, the Board finds that there is distinction between financial reporting and reimbursement principles. Reimbursement principles look to reasonable cost and relationship to patient care, whereas generally accepted accounting principles seek to standardize financial reporting. The Board is in agreement with the Provider with respect to the place generally accepted accounting principles have in determining reasonable cost related to patient care. However, in this case generally accepted accounting principles distort Medicare reimbursement and are superseded by a Medicare principle. Therefore, interest during construction

should be capitalized and the cost recovered over the useful life of the asset as it directly relates to rendering patient care.

Although the Board is not in a position to rule on the issuance of § 206, HIM-15-1, pursuant to the Administrative Procedures Act, it does find the section to be quite explicit with respect to capitalizing interest during construction. However, it should be pointed out that § 206 was promulgated in November 1968 which appears to be well before the Provider entered into the financing agreement which is the subject of this appeal.

Finally, while the Board might agree with the Provider's present value approach on a purely theoretical and academic basis, the Board finds no provision in the Medicare Law to reimburse costs using either present value theory or any reflection of inflationary trends.

**Issue No. 3 — Television and Telephone**

The Board concurs with the Intermediary with respect to these issues. Regulation § 405.310(j) explicitly states that the program will not make any payment for personal comfort items. That section goes on to illustrate personal comfort items to be a television set or telephone service. A similar provision for the exclusion of personal comfort items is found in § 1862(a)(1) of the Social Security Act. The fact that patient telephones and televisions are in every hospital room does not convert the items to other than personal comfort ones.

Although the Provider introduced depositions from two of its practicing physicians with respect to the effect that telephone service and television sets have on their patients, the Board is not convinced that these services are reasonable and necessary for the diagnosis or treatment of illness or injury. As argued by the Intermediary, the depositions introduced were the opinions of two physicians who practiced at Presbyterian. Their conclusions do not constitute the results of a scientific study as to how these services impact on the diagnosis or treatment of illness or injury. Accordingly, the Provider's argument lacks statistical validity, as well as the depositions being biased.

## DECISION

**Issue No. 1 — Hill-Burton Interest Subsidy**

The costs associated with the free care requirements of a Hill-Burton interest subsidy are not allowable costs. The Intermediary is affirmed.

**Issue No. 2 — Interest During Construction**

Interest during construction must be capitalized. The Intermediary is affirmed.

**Issue No. 3 — Telephone and Television Costs**

The Intermediary properly determined that telephone service and television sets are personal comfort items.

**Board Members Participating:**

*Issues 1 and 3*

Arthur P. Owens
Carolyn B. Lewis
Harold Hinderer

*Issue 2*

Arthur P. Owens (Dissent)
Carolyn B. Lewis
Harold Hinderer

FOR THE BOARD

Arthur P. Owens, Chairman

February 28, 1979

**DISSENTING OPINION OF Mr. Arthur P. Owens:**

Much emphasis has been given to the fact that during the period of construction it is obviously impossible to provide patient care within the facility while construction is in progress. With this as a given, the Medicare program is quite clear in its pronouncement that a cost, to be reimbursable, must be related to patient care. Therefore, since there is no patient care provided during the period of construction, there can be no reimbursement provided during the construction period, including the interest incurred on borrowed construction funds.

However, the Program will permit the interest incurred on borrowed funds during the construction period to be capitalized over the life of the asset being constructed. The Program also allows organization and start-up costs to be amortized over a 60-month period. In effect, the Program has recognized that a mechanism for cost recovery of the above-described outlay of funds is proper. Both parties to the controversy (the Intermediary adhering the Program directives) and the Provider agree that the costs are allowable. Rather, it is a dispute as to the proper methodolog, to be employed to recover these costs.

In my opinion, interest expense incurred during the construction period is more properly akin to a start-up cost as opposed to, in effect, adding this expense to the construction cost of the building. What is more of a "start-up cost" than the period of actual ground breaking and subsequent erection of the building and installation of equipment! Moreover, as Mr. Herbert Miller, a man renowned as an accounting authority, pointed out during his testimony in a prior hearing, if one is to capitalize actual interest during construction, then the implicit cost of capital should also be self-financed. In my opinion, Mr. Miller's statement pinpoints the inconsistency of the instructions contained in the Provider Reimbursement Manual. In other words, two identical structures, Building A, which is self-financed, is worth X dollars while Building B, financed through borrowed funds, is worth X dollars plus the interest expense incurred during construction. This makes no sense.

The obvious financial impairment to the Provider from capitalizing interest during construction in this manner rests within the inflationary environment which shows no sign of abating. The obvious result is reimbursement to the Provider over some three decades or more with severely discounted dollars as contrasted with the dollars initially remitted to the lender at the time of construction.

Even though amortization over a 60-month period is not ideal, it appears far more reasonable than extending the recovery of this expense over the entire estimated useful life of the assets. I agree with the majority to the extent that it is unreasonable to charge the entire expense to the program in the year when it is incurred. To do so would result in a double standard because the obvious effect would be that one provider which did not have an ongoing facility and was starting anew would lose the ability to charge any of the interest cost to a third-party payor during a year when such third party had no patients in the facility. The current case under review is, of course, the converse. However, using the life of the asset for reimbursement within this inflationary environment is too long. In consideration of the fact that the Program recognizes a recovery of start-up costs over a 60-month period, it appears to this Board member that the recognition of interest expense during construction is far more of a start-up cost than an addition to the value of the building and I urge that such interest expense be recognized as such. It is far more reasonable.

Arthur P. Owens

CN 78-96

## APPENDIX A

(40 F.R.1023, Jan. 6, 1975)

**§ 405.310 Types of expenses not covered.**

Notwithstanding any other provisions of this part 405, no payment (except as provided in §§ 403.330-403.332) may be made for any expenses incurred for the following items or services:

(j) Personal comfort items and services (for example, a television set, or telephone services, etc.);

§ 405.419 Interest expense.

(a) *Principle.* Necessary and proper interest on both current and capital indebtedness is an allowable cost. However, interest cost incurred as a result of judicial review by a Federal court (as described in § 405.451(l)) is not an allowable cost.

(b) *Definitions* — (1) *Interest.* Interest is the cost incurred for funds borrowed for a relatively short term. This is usually for such purposes as working capital for normal operating expenses. Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes, such as acquisition of facilities and equipment, and capital improvements. Generally, loans for capital purposes are long-term loans.

(2) *Necessary.* Necessary requires that the interest:

(i) Be incurred on a loan made to satisfy a financial need of the provider. Loans which result in excess funds or investments would not be considered necessary.

(ii) Be incurred on a loan made for a purpose reasonably related to patient care.

(iii) Be reduced by investment income except where such income is from gifts and grants, whether restricted or unrestricted, and which are held separate and not commingled with other funds. Income from funded deprecia-

tion or provider's qualified pension fund is not used to reduce interest expense. Interest received as a result of judicial review by a Federal court (as described in § 405.454(l)) is not used to reduce interest expense.

(3) *Proper.* Proper requires that interest:

(i) Be incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market existing at the time the loan was made.

(ii) Be paid to a lender not related through control or ownership, or personal relationship to the borrowing organization. However, interest is allowable if paid on loans from the provider's donor-restricted funds, the funded depreciation account, or provider's qualified pension fund.

(c) *Borrower-lender relationship.* (1) To be allowable, interest expense must be incurred on indebtedness established with lenders or lending organizations not related through control, ownership, or personal relationship to the borrower. Presence of any of these factors could affect the "bargaining" process that usually accompanies the making of a loan, and could thus be suggestive of an agreement on higher rates of interest or of unnecessary loans. Loans should be made under terms and conditions that a prudent borrower would make in arms-length transactions with lending institutions. The intent of this provision is to assure that loans are legitimate and needed, and that the interest rate is reasonable. Thus, interest paid by the provider to partners, stockholders, or related organizations of the provider would not be allowable. Where the owner uses his own funds in a business, it is reasonable to treat the funds as invested funds or capital, rather than borrowed funds. Therefore, where interest on loans by partners, stockholders, or related organizations is disallowed as a cost solely because of the relationship factor, the principal of such loans shall be treated as invested funds in the computation of the provider's equity capital under § 405.420.

(2) Exceptions to the general rule regarding interest on loans from controlled sources of funds are made in the following circumstances. Interest on loans to providers by partners, stockholders, or related organizations made prior to July 1,

1966, is allowable as cost, provided that the terms and conditions of payment of such loans have been maintained in effect without modification subsequent to July 1, 1966. Where the general fund of a provider "borrows" from a donor-restricted fund and pays interest to the restricted fund, this interest expense is an allowable cost. The same treatment is accorded interest paid by the general fund on money "borrowed" from the funded depreciation account of the provider or from the provider's qualified pension fund. In addition, if a provider operated by members of a religious order borrows from the order, interest paid to the order is an allowable cost.

(3) Where funded depreciation is used for purposes other than improvement, replacement, or expansion of facilities or equipment related to patient care, allowable interest expense is reduced to adjust for offsets not made in prior years for earnings on funded depreciation. A similar treatment will be accorded deposits in the provider's qualified pension fund where such deposits are used for other than the purpose for which the fund was established.

(4) (Deleted)

(d) *Loans not reasonably related to patient care.* Loans made to finance that portion of the cost of acquisition of a facility that exceeds historical cost as determined under § 405.415 (b) or the cost basis as determined under § 405.415 (g) are not considered to be for a purpose reasonably related to patient care. In determining whether a loan was made for this purpose, it should be assumed that any owner's investment or funds are applied first to the tangible assets, then to the intangible assets other than goodwill and lastly to the goodwill. Where the owner's investment or funds are not sufficient to cover the cost allowed for tangible assets, funds borrowed to finance the acquisition are applied to the portion of the allowed cost of the tangible assets not covered by the owner's investment, then to the intangible assets other than goodwill and lastly to the goodwill.

(e) *Limitation on Federal participation for capital expenditures.* See § 405.435, "Nonallowable costs related to certain capital expenditures" for situations where interest on borrowed funds is not an allowable cost.

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## APPENDIX C

§ 405.420 Bad debts, charity, and courtesy allowances.

(a) *Principle.* Bad debts, charity, and courtesy allowances are deductions from revenue and are not to be included in allowable cost; however, bad debts attributable to the deductibles and coinsurance amounts are reimbursable under the program.

(b) *Definitions* — (1) *Bad debts.* Bad debts are amounts considered to be uncollectible from accounts and notes receivable which were created or acquired in providing services. "Accounts receivable" and "notes receivable" are designations for claims arising from the rendering of services, and are collectible in money in the relatively near future.

(2) *Charity allowances.* Charity allowances are reductions in charges made by the provider of services because of the indigence or medical indigence of the patient.

(3) *Courtesy allowances.* Courtesy allowances indicate a reduction in charges in the form of an allowance to physicians, clergy, members of religious orders, and others as approved by the governing body of the provider, for services received from the provider. Employee fringe benefits, such as hospitalization and personnel health programs, are not considered to be courtesy allowances.

(c) *Normal accounting treatment: reduction in revenue.* Bad debts, charity, and courtesy allowances represent reductions in revenue. The failure to collect charges for services rendered does not add to the cost of providing the services. Such costs have already been incurred in the production of the services.

(d) *Requirements for title XVIII.* Under title XVIII of the Act, costs of covered services furnished beneficiaries are not to be borne by individuals not covered by the health insurance program, and conversely, costs of services provided for other than beneficiaries are not to be borne by the health insurance program. Uncollected revenue related to services

rendered to beneficiaries of the program generally means the provider has not recovered the cost of services covered by that revenue. The failure of beneficiaries to pay the deductible and coinsurance amounts can result in the related costs of covered services being borne by other than beneficiaries of title XVIII. To assure that such covered service costs are not borne by others, the costs attributable to the deductible and coinsurance amounts which remain unpaid are added to the title XVIII share of allowable costs. Bad debts arising from other sources are not allowable costs.

(e) *Criteria for allowable bad debt.* A bad debt must meet the following criteria to be allowable:

(1) The debt must be related to covered services and derived from deductible and coinsurance amounts.

(2) The provider must be able to establish that reasonable collection efforts were made.

(3) The debt was actually uncollectible when claimed as worthless.

(4) Sound business judgment established that there was no likelihood of recovery at any time in the future.

(f) *Charging of bad debts and bad debt recoveries.* The amounts uncollectible from specific beneficiaries are to be charged off as bad debts in the accounting period in which the accounts are deemed to be worthless. In some cases an amount previously written off as a bad debt and allocated to the program may be recovered in a subsequent accounting period; in such cases the income therefrom must be used to reduce the cost of beneficiary services for the period in which the collection is made.

(g) *Charity allowances.* Charity allowances have no relationship to beneficiaries of the health insurance program and are not allowable costs. The cost to the provider of employee fringe-benefit programs is an allowance element of reimbursement.

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## APPENDIX D

**§ 405.451 Cost related to patient care.**

(a) *Principle.* All payments to providers of services must be based on the reasonable cost of services covered under title XVIII, of the Act and related to the care of beneficiaries. Reasonable cost includes all necessary and proper costs incurred in rendering the services, subject to principles relating to specific items of revenue and cost. However, for cost reporting periods beginning after December 31, 1973, payments to providers of services are based on the lesser of the reasonable cost of services covered under title XVIII of the Act and furnished to program beneficiaries or the customary charges to the general public for such services, as provided for in § 405.455.

(b) *Definitions* — (1) *Reasonable Cost.* Reasonable cost of any services must be determined in accordance with regulations establishing the method or methods to be used, and the items to be included. The regulations in this subpart take into account both direct and indirect costs of providers of services. The objective is that under the methods of determining costs, the costs with respect to individuals covered by the program will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by the program. These regulations also provide for the making of suitable retroactive adjustments after the provider has submitted fiscal and statistical reports. The retroactive adjustment will represent the difference between the amount received by the provider during the year for covered services from both title XVIII and the beneficiaries and the amount determined in accordance with an accepted method of cost apportionment to be the actual cost of services rendered to beneficiaries during the year.

(2) *Necessary and proper costs.* Necessary and proper costs are costs which are appropriate and helpful in developing and maintaining the operation of patient care facilities

and activities. They are usually costs which are common and accepted occurrences in the field of the provider's activity.

(c) *Application.* (1) It is the intent of title XVIII of the Act that payments to providers of services should be fair to the providers, to the contributors to the health-insurance trust funds, and to other patients.

(2) The costs of providers services vary from one provider to another and the variations generally reflect differences in scope of services and intensity of care. The provision in title XVIII of the Act for payment of reasonable cost of services is intended to meet the actual costs, however widely they may vary from one institution to another. This is subject to a limitation where a particular institution's costs are found to be substantially out of line with other institutions in the same area which are similar in size, scope of services, utilization, and other relevant factors.

(3) The determination of reasonable cost of services must be based on cost related to the care of beneficiaries of title XVIII of the Act. Reasonable cost includes all necessary and proper expenses incurred in rendering services, such as administrative costs, maintenance costs, and premium payments for employee health and pension plans. It includes both direct and indirect costs and normal standby costs. However, where the provider's operating costs include amounts not related to patient care, specifically not reimbursable under the program, or flowing from the provision of luxury items or services (that is, those items or services substantially in excess of or more expensive than those generally considered necessary for the provision of needed health services), such amounts will not be allowable. The reasonable cost basis of reimbursement contemplates that the providers of services would be reimbursed the actual costs of providing quality care however widely the actual costs may vary from provider to provider and from time to time for the same provider.

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## APPENDIX E

### 206. INTEREST DURING PERIOD OF CONSTRUCTION

Frequently, providers may borrow funds to construct facilities or to enlarge existing facilities. Usually, construction of facilities will extend over a long period of time, during which interest costs on the loan are incurred. Interest costs incurred during the period of construction must be capitalized as a part of the cost of the facility. The period of construction is considered to extend to the date the facility is put into use for patient care.

If the construction is an addition to an existing facility, interest incurred during the construction period on funds borrowed to construct the addition must be capitalized as a cost of the addition. After the construction period, interest on the loan is allowable as an operating cost.

Where a bond issue is involved, any bond discount and expense, or bond premium amortized during the period of construction, is included in the capitalized cost of the facility constructed.

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## APPENDIX F

### 328. CHARITY, COURTESY, AND THIRD-PARTY PAYER ALLOWANCES — COST TREATMENT

Charity, courtesy, and third-party payer allowances are not reimbursable Medicare costs. Charges related to services subject to these allowances should be recorded at the full amount charged to all patients, and the allowances should be appropriately shown in a revenue reduction account. The amount reflecting full charges must then be used as applicable to apportion costs and in determining customary charges for application of the lower of costs or charges provision.

*Example* — The provider entered into an agreement with a third-party payer to render services at 25 percent below charges. Accordingly, for an X-ray service with a charge of $40, the provider billed the third-party payer $30. The charge of $40 would be used to apportion costs and the $10 allowance would be recorded in a revenue reduction account.

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## APPENDIX G

### 2106. COST OF TELEPHONE, TELEVISION, AND RADIO

2106.1 *General.* — The *full* costs of items or services such as telephone, television, and radio which are located in patient accommodations and which are furnished solely for the personal comfort of the patients (full costs include costs both directly associated with personal comfort items or services plus an appropriate share of indirect costs) are not includable in allowable costs of providers under the Medicare program. To illustrate, the full costs of telephones used solely for the personal comfort of patients include not only costs directly associated with these telephones, such as the rates billed by the public utility, but also an appropriate share of indirect telephone costs, e.g., operators' salaries, equipment, space-related costs of switchboard and other equipment, etc., as well as any other overhead that may be applicable thereto. The costs of television and radio services are includable in allowable costs where furnished to the general patient population in areas of providers other than patient accommodations — e.g., day rooms, recreation rooms, waiting rooms, etc.

The cost of a nurse-patient communication system that has no capability for other than communications between patient and nurse (or other facility employees) are includable in allowable costs. Similarly, costs of closed circuit television monitoring systems used by providers for surveillance of patients or for security, teaching, or demonstration programs which serve purposes of patient care or which are otherwise needed for the provider's operations and have no capability beyond these stated purposes are includable in allowable costs.

The cost of television and radio located in lounges and other areas designated for the use of provider employees is includable in allowable costs.

2106.2 *Combination Purpose Systems.* — Some nurse-patient communication systems based on closed circuit television are used in part for bringing in outside entertainment. Likewise, some patient communication systems operate through the telephone line and such a system may also be used, in part, by the patient for making or receiving outside calls.

Where providers use the combined systems, the basic cost of the components designed and used for patient care communication will be an allowable cost. Any incremental costs attributable to the additional components or capability for providing the patient's entertainment or convenience are not allowable and must be excluded. Where this distinction cannot be clearly made, particularly as it applies to maintenance, the intermediary may approve an allocation covering these incremental costs (usually nominal) based on an equitable sharing.

Occasionally, nurse call systems which do not provide closed circuit television for patient care services are tied by some adjunct linkage into the audio component of a television set. In such instances, the cost of the set and maintenance of the equipment providing the television capability is not an allowable cost, except to the extent the provider can demonstrate and the intermediary approves an equitable share (usually nominal) attributable directly to costs arising out of the adjunct linkage and use of the set for nurse call.

## TEXT OF AMENDMENTS TO THE CONSTITUTION

### AMENDMENT [I]

Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof; or abridging the freedom of speech, or of the press; or the right of the people peaceably to assemble, and to petition the Government for a redress of grievances.

## 28 U.S.C. 1254(1)

### § 1254. Courts of appeals; certiorari; appeal; certified questions

Cases in the courts of appeals may be reviewed by the Supreme Court by the following methods:

(1) By writ of certiorari granted upon the petition of any party to any civil or criminal case, before or after rendition of judgment or decree;

## 42 U.S.C. § 1395

### § 1395. Prohibition against any Federal interference

Nothing in this subchapter shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person.

## 42 USC § 1395c

### PART A — HOSPITAL INSURANCE BENEFITS FOR AGED AND DISABLED

### § 1395c. Description of program

The insurance program for which entitlement is established by sections 426 and 426-1 of this title provides basic protection against the costs of hospital and related post-hospital services in accordance with this part for (1) individuals who are age 65 or over and are entitled to retirement benefits under subchapter II of this chapter or under the railroad retirement system, (2) individuals under age 65 who have been entitled for not less than 24 consecutive months to benefits under subchapter II of this chapter or under the railroad retirement system on the basis of a

disability, and (3) certain individuals who do not meet the conditions specified in either clause (1) or (2) but who are medically determined to have end stage renal disease.

## 42 USC § 1395f

### § 1395f. Conditions of and limitations on payment for services — Requirement of requests and certifications

(a) Except as provided in subsections (d) and (g) of this section and in section 1395mm of this title, payment for services furnished an individual may be made only to providers of services which are eligible therefor under section 1395cc of this title and only if —

(1) written request, signed by such individual, except in cases in which the Secretary finds it impracticable for the individual to do so, is filed for such payment in such form, in such manner, and by such person or persons as the Secretary may by regulation prescribe, no later than the close of the period of 3 calendar years following the year in which such services are furnished (deeming any services furnished in the last 3 calendar months of any calendar year to have been furnished in the succeeding calendar year) except that where the Secretary deems that efficient administration so requires, such period may be reduced to not less than 1 calendar year;

(2) a physician certifies (and recertifies, where such services are furnished over a period of time, in such cases, with such frequency, and accompanied by such supporting material, appropriate to the case involved, as may be provided by regulations, except that the first of such recertifications shall be required in each case of inpatient hospital services not later than the 20th day of such period).

## 42 USC § 1395y (a) (6)

**§ 1395y. Exclusions from coverage**

(a) Notwithstanding any other provision of this subchapter, no payment may be made under part A or part B of this subchapter for any expenses incurred for items or services —

(6) which constitute personal comfort items;

## 42 USC § 1395oo

**§ 1395oo. Provider Reimbursement Review Board — Establishment.**

(a) Any provider of services which has filed a required cost report within the time specified in regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board (hereinafter referred to as the "Board") which shall be established by the Secretary in accordance with subsection (h) of this section, if —

(1) such provider —

(A) is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to section 1395h of this title as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this subchapter for the period covered by such report,

(B) has not received such final determination from such intermediary on a timely basis after filing such report, where such report complied with the rules and regulations of the Secretary relating to such report, or

(C) has not received such final determination on a timely basis after filing a supplementary cost report, where such cost report did not so comply and such supplementary cost report did so comply.

(2) the amount in controversy is $10,000 or more, and

(3) such provider files a request for a hearing within 180 days after notice of the intermediary's final determination under paragraph (1) (A) or with respect to appeals pursuant to paragraph (1) (B) or (C), within 180 days after notice of such determination would have been received if such determination had been made on a timely basis.

**Appeals by groups**

(b) The provisions of subsection (a) of this section shall apply to any group of providers of services if each provider of services in such group would, upon the filing of an appeal (but without regard to the $10,000 limitation), be entitled to such a hearing, but only if the matters in controversy involve a common question of fact or interpretation of law or regulations and the amount in controversy is, in the aggregate, $50,000 or more.

**Right to counsel; rules of evidence**

(c) At such hearing, the provider of services shall have the right to be represented by counsel, to introduce evidence, and to examine and cross-examine witnesses. Evidence may be received at any such hearing even though inadmissible under rule of evidence applicable to court procedure.

**Decisions of Board**

(d) A decision by the Board shall be based upon the record made at such hearing, which shall include the evidence considered by the intermediary and such other evidence as may be obtained or received by the Board, and shall be supported by substantial evidence when the record is viewed as a whole. The Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination.

**Rules and Regulations**

(e) The Board shall have full power and authority to make rules and establish procedures, not inconsistent with the provisions of this subchapter or regulations of the Secretary, which are necessary or appropriate to carry out the provisions of this section. In the course of any hearing the Board may administer oaths and affirmations. The provisions of subsections (d), (e), and (f) of section 405 of this title with respect to subpenas shall apply to the Board to the same extent as they apply to the Secretary with respect to subchapter II of this chapter.

**Certain findings not reviewable**

(g) The finding of a fiscal intermediary that no payment may be made under this subchapter for any expenses incurred for items or services furnished to an individual because such items or services are listed in section 1395y of this title shall not be reviewed by the Board, or by any court pursuant to an action brought under subsection (f) of this section.

**Finality of decision; judicial review; jurisdiction; venue; interest on amount in controversy**

(f) (1) A decision of the Board shall be final unless the Secretary, on his own motion, and within 60 days after the provider of services is notified of the Board's decision, reverses, affirms, or modifies the Board's decision. Providers shall have the right to obtain judicial review of any final decision of the Board, or of any reversal, affirmance, or modification by the Secretary, by a civil action commenced within 60 days of the date on which notice of any final decision by the Board or of any reversal, affirmance, or modification by the Secretary is received. Such action shall be brought in the district court of the United States for the judicial district in which the provider is located or in the District Court for the District of Columbia and shall be tried pursuant to the applicable provisions under chapter 7 of

Title 5, notwithstanding any other provisions in section 405 of this title.

(2) Where a provider seeks judicial review pursuant to paragraph (1), the amount in controversy shall be subject to annual interest beginning on the first day of the first month beginning after the 180-day period as determined pursuant to subsection (a)(3) of this section and equal to the rate of return on equity capital established by regulation pursuant to section 1395x (v)(1)(B) of this title and in effect at the time the civil action authorized under paragraph (1) is commenced, to be awarded by the reviewing court in favor of the prevailing party.

(3) No interest awarded pursuant to paragraph (2) shall be deemed income or cost for the purposes of determining reimbursement due providers under this chapter.

**Composition and compensation**

(h) The Board shall be composed of five members appointed by the Secretary without regard to the provisions of Title 5, governing appointments in the competitive services. Two of such members shall be representative of providers of services. All of the members of the Board shall be persons knowledgeable in the field of cost reimbursement, and at least one of them shall be a certified public accountant. Members of the Board shall be entitled to receive compensation at rates fixed by the Secretary, but not exceeding the rate specified (at the time the service involved is rendered by such members) for grade GS-18 in section 5332 of Title 5. The term of office shall be three years, except that the Secretary shall appoint the initial members of the Board for shorter terms to the extent necessary to permit staggered terms of office.

**Technical and clerical assistance**

(i) The Board is authorized to engage such technical assistance as may be required to carry out its functions, and the Secretary shall, in addition, make available to the Board

such secretarial, clerical, and other assistance as the Board may require to carry out its functions.

## PUBLIC LAW 96-247

## CIVIL RIGHTS OF INSTITUTIONALIZED PERSONS ACT

An Act to authorize actions for redress in cases involving deprivations of rights of institutionalized persons secured or protected by the Constitution or laws of the United States.

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,* That this Act may be cited as the "Civil Rights of Institutionalized Persons Act".

### SEC. 2. DEFINITIONS.

As used in this Act —

(1) The term "institution" means any facility or institution —

(A) which is owned, operated, or managed by, or provides services on behalf of any State or political subdivision of a State; and

(B) which is —

(i) for persons who are mentally ill, disabled, or retarded, or chronically ill or handicapped;

(ii) a jail, prison, or other correctional facility;

(iii) a pretrial detention facility;

(iv) for juveniles —

(I) held awaiting trial;

(II) residing in such facility or institution for purposes of receiving care or treatment; or

(III) residing for any State purpose in such facility or institution (other than a residential facility providing only elementary or secondary education that is not an institution in which reside juveniles who are adjudicated delinquent, in need of supervision, neglected, placed in State custody, mentally ill or disabled, mentally retarded, or chronically ill or handicapped); or

(v) providing skilled nursing, intermediate or long-term care, or custodial or residential care.

(2) Privately owned and operated facilities shall not be deemed "institutions" under this Act if —

(A) the licensing of such facility by the State constitutes the sole nexus between such facility and such State;

(B) the receipt by such facility, on behalf of persons residing in such facility, of payments under title XVI, XVIII, or under a State plan approved under title XIX, of the Social Security Act, constitutes the sole nexus between such facility and such State; or

(C) the licensing of such facility by the State, and the receipt by such facility, on behalf of persons residing in such facility, of payments under title XVI, XVIII, or under a State plan approved under title XIX, of the Social Security Act, constitutes the sole nexus between such facility and such State;

(3) The term "person" means an individual, a trust or estate, a partnership, an association, or a corporation;

(4) The term "State" means any of the several States, the District of Columbia, the Commonwealth of Puerto Rico, or any of the territories and possessions of the United States.

(5) The term "legislative days" means any calendar day on which either House of Congress is in session.

**SEC. 3. INITIATION OF ACTIONS.**

(a) Whenever the Attorney General has reasonable cause to believe that any State or political subdivision of a State, official, employee, or agent thereof, or other person

acting on behalf of a State or political subdivision of a State is subjecting persons residing in or confined to an institution, as defined in section 2, to egregious or flagrant conditions which deprive such persons of any rights, privileges, or immunities secured or protected by the Constitution or laws of the United States causing such persons to suffer grievous harm, and that such deprivation is pursuant to a pattern or practice of resistance to the full enjoyment of such rights, privileges, or immunities, the Attorney General, for or in the name of the United States, may institute a civil action in any appropriate United States district court against such party for such equitable relief as may be appropriate to insure the minimum corrective measures necessary to insure the full enjoyment of such rights, privileges, or immunities, except that such equitable relief shall be available under this Act to persons residing in or confined to an institution as defined in section 2(1) (B) (ii) only insofar as such persons are subjected to conditions which deprive them of rights, privileges, or immunities secured or protected by the Constitution of the United States.

(b) In any action commenced under this section, the court may allow the prevailing party, other than the United States, a reasonable attorney's fee against the United States as part of the costs.

(c) Any complaint filed by the Attorney General pursuant to this section shall be personally signed by him.

SEC. 4. CERTIFICATION REQUIREMENTS.

(a) At the time of the commencement of an action under section 2 the Attorney General shall certify to the court —

(1) that at least 49 calendar days previously he has notified in writing the Governor or chief executive officer and attorney general or chief legal officer of the appropriate State or political subdivision and the director of the institution of —

(A) the alleged conditions which deprive rights, privileges, or immunities secured or protected by the

Constitution or laws of the United States and the alleged pattern or practice of resistance to the full enjoyment of such rights, privileges, or immunities;

(B) the supporting facts giving rise to the alleged conditions and the alleged pattern or practice, including the dates or time period during which the alleged conditions and pattern or practice of resistance occurred; and when feasible, the identity of all persons reasonably suspected of being involved in causing the alleged conditions and pattern or practice at the time of the certification, and the date on which the alleged conditions and patterns or practice were first brought to the attention of the Attorney General; and

(C) the minimum measures which he believes may remedy the alleged conditions and the alleged pattern or practice of resistance;

(2) that he has notified in writing the Governor or chief executive officer and attorney general or chief legal officer of the appropriate State or political subdivision and the director of the institution of his intention to commence an investigation of such institution, that such notice was delivered at least seven days prior to the commencement of such investigation and that between the time of such notice and the commencement of an action under section 3 of this Act —

(A) he has made a reasonable good faith effort to consult with the Governor or chief executive officer and attorney general or chief legal officer of the appropriate State or political subdivision and the director of the institution, or their designees, regarding financial, technical, or other assistance which may be available from the United States and which he believes may assist in the correction of such conditions and pattern or practice of resistance;

(B) he has encouraged the appropriate officials to correct the alleged conditions and pattern or practice of resistance through informal methods of conference, conciliation and persuasion, including, to the extent feasible, discussion of

the possible costs and fiscal impacts of alternative minimum corrective measures, and it is his opinion that reasonable efforts at voluntary correction have not succeeded; and

(C) he is satisfied that the appropriate officials have had a reasonable time to take appropriate action to correct such conditions and pattern or practice, taking into consideration the time required to remodel or make necessary changes in physical facilities or relocate residents, reasonable legal or procedural requirements, the urgency of the need to correct such conditions, and other circumstances involved in correcting such conditions; and

(3) that he believes that such an action by the United States is of general public importance and will materially further the vindication of rights, privileges, or immunities secured or protected by the Constitution or laws of the United States.

(b) Any certification made by the Attorney General pursuant to this section shall be personally signed by him.

**SEC. 5. INTERVENTION IN ACTIONS.**

(a) (1) Whenever an action has been commenced in any court of the United States seeking relief from egregious or flagrant conditions which deprive persons residing in institutions of any rights, privileges, or immunities secured or protected by the Constitution or laws of the United States causing them to suffer grievous harm and the Attorney General has reasonable cause to believe that such deprivation is pursuant to a pattern or practice of resistance to the full enjoyment of such rights, privileges, or immunities, the Attorney General, for or in the name of the United States, may intervene in such action upon motion by the Attorney General.

(2) The Attorney General shall not file a motion to intervene under paragraph (1) before 90 days after the commencement of the action, except that if the court determines

it would be in the interests of justice, the court may shorten or waive the time period.

(b) (1) The Attorney General shall certify to the court in the motion to intervene filed under subsection (a) —

(A) that he has notified in writing, at least fifteen days previously, the Governor or chief executive officer, attorney general or chief legal officer of the appropriate State or political subdivision, and the director of the institution of —

(i) the alleged conditions which deprive rights, privileges, or immunities secured or protected by the Constitution or laws of the United States and the alleged pattern or practice of resistance to the full enjoyment of such rights, privileges, or immunities;

(ii) the supporting facts giving rise to the alleged conditions, including the dates and time period during which the alleged conditions and pattern or practice of resistance occurred; and

(iii) to the extent feasible and consistent with the interests of other plaintiffs, the minimum measures which he believes may remedy the alleged conditions and the alleged pattern or practice of resistance; and

(B) that he believes that such intervention by the United States is of general public importance and will materially further the vindication of rights, privileges, or immunities secured or protected by the Constitution or laws of the United States.

(2) Any certification made by the Attorney General pursuant to this subsection shall be personally signed by him.

(c) Any motion to intervene made by the Attorney General pursuant to this section shall be personally signed by him.

(d) In any action in which the United States joins as an intervenor under this section, the court may allow the pre-

vailing party, other than the United States, a reasonable attorney's fee against the United States as part of the costs. Nothing in this subsection precludes the award of attorney's fees available under any other provisions of the United States Code.

**SEC. 6. PROHIBITION OF RETALIATION.**

No person reporting conditions which may constitute a violation under this Act shall be subjected to retaliation in any manner for so reporting.

**SEC. 7. EXHAUSTION OF REMEDIES.**

(a) (1) Subject to the provisions of paragraph (2), in any action brought pursuant to section 1979 of the Revised Statutes of the United States (42 U.S.C. 1983) by an adult convicted of a crime confined in any jail, prison, or other correctional facility, the court shall, if the court believes that such a requirement would be appropriate and in the interests of justice, continue such case for a period of not to exceed ninety days in order to require exhaustion of such plain, speedy, and effective administrative remedies as are available.

(2) The exhaustion of administrative remedies under paragraph (1) may not be required unless the Attorney General has certified or the court has determined that such administrative remedies are in substantial compliance with the minimum acceptable standards promulgated under subsection (b).

(b) (1) No later than one hundred eighty days after the date of enactment of this Act, the Attorney General shall, after consultation with persons, State and local agencies, and organizations with background and expertise in the area of corrections, promulgate minimum standards for the development and implementation of a plain, speedy, and effective system for the resolution of grievances of adults confined in any jail, prison, or other correctional facility. The Attorney General shall submit such proposed standards for publication in the Federal Register in accordance with section 553

of title 5, United States Code. Such standards shall take effect thirty legislative days after publication unless, within such period, either House of Congress adopts a resolution of disapproval of such standards.

(2) The minimum standards shall provide —

(A) for an advisory role for employees and inmates of any jail, prison, or other correctional institution (at the most decentralized level as is reasonably possible), in the formulation, implementation, and operation of the system;

(B) specific maximum time limits for written replies to grievances with reasons thereto at each decision level within the system;

(C) for priority processing of grievances which are of an emergency nature, including matters in which delay would subject the grievant to substantial risk of personal injury or other damages;

(D) for safeguards to avoid reprisals against any grievant or participant in the resolution of a grievance; and

(E) for independent review of the disposition of grievances, including alleged reprisals, by a person or other entity not under the direct supervision or direct control of the institution.

(c) (1) The Attorney General shall develop a procedure for the prompt review and certification of systems for the resolution of grievances of adults confined in any jail, prison, or other correctional facility, or pretrial detention facility, to determine if such systems, as voluntarily submitted by the various States and political subdivisions, are in substantial compliance with the minimum standards promulgated under subsection (b).

(2) The Attorney General may suspend or withdraw the certification under paragraph (1) at any time that he has reasonable cause to believe that the grievance procedure is no longer in substantial compliance with the minimum standards promulgated under subsection (b).

(d) The failure of a State to adopt or adhere to an administrative grievance procedure consistent with this section shall not constitute the basis for an action under section 3 or 5 of this Act.

## SEC. 8. REPORT TO CONGRESS.

The Attorney shall include in his report to Congress on the business of the Department of Justice prepared pursuant to section 522 of title 28, United States Code —

(1) a statement of the number, variety, and outcome of all actions instituted pursuant to this Act including the history of, precise reasons for, and procedures followed in initiation or intervention in each case in which action was commenced;

(2) a detailed explanation of the procedures by which the Department has received, reviewed and evaluated petitions or complaints regarding conditions in institutions;

(3) an analysis of the impact of actions instituted pursuant to this Act, including, when feasible, an estimate of the costs incurred by States and other political subdivisions;

(4) a statement of the financial, technical, or other assistance which has been made available from the United States to the State in order to assist in the correction of the conditions which are alleged to have deprived a person of rights, privileges, or immunities secured or protected by the Constitution or laws of the United States; and

(5) the progress made in each Federal institution toward meeting existing promulgated standards for such institutions or constitutionally guaranteed minima.

## SEC. 9. PRIORITIES FOR USE OF FUNDS.

(a) It is the intent of Congress that deplorable conditions in institutions covered by this Act amounting to deprivations

of rights protected by the Constitution or laws of the United States be corrected, not only by litigation as contemplated in this Act, but also by the voluntary good faith efforts of agencies of Federal, State and local governments. It is the further intention of Congress that where Federal funds are available for use in improving such institutions, priority should be given to the correction or elimination of such unconstitutional or illegal conditions which may exist. It is not the intent of this provision to require the redirection of funds from one program to another or from one State to another.

**SEC. 10. NOTICE TO FEDERAL DEPARTMENTS.**

At the time of notification of the commencement of an investigation of an institution under section 3 or of the notification of an intention to file a motion to intervene under section 5 of this Act, and if the relevant institution receives Federal financial assistance from the Department of Health and Human Services or the Department of Education, the Attorney General shall notify the appropriate Secretary of his action and the reasons for such action and shall consult with such officials. Following such consultation, the Attorney General may proceed with an action under this Act if he is satisfied that such action is consistent with the policies and goals of the executive branch.

**SEC. 11. DISCLAIMER — STANDARDS OF CARE.**

Provisions of this Act shall not authorize promulgation of regulations defining standards of care.

**SEC. 12. DISCLAIMER — PRIVATE LITIGATION.**

The provisions of this Act shall in no way expand or restrict the authority of parties other than the United States to enforce the legal rights which they may have pursuant to existing law with regard to institutionalized persons. In this regard, the fact that the Attorney General may be conducting an investigation or contemplating litigation pursuant to this Act shall not be grounds for delay of or prejudice to any litigation on behalf of parties other than the United States.

Approved May 23, 1980.

## 42 CFR 405.310(j)

**§ 405.310 Types of expenses not covered.**

Notwithstanding any other provisions of this Part 405, no payment may be made for any expenses incurred for the following items or services:

(j) Personal comfort items and services (for example a television set, or telephone service, etc.);

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MEDICARE
Part A Intermediary Letter
Part B Intermediary Letter

Department of Health and Human Services
Health Care Financing Administration

Part A No. 80-35
Part B No. 80-28

Date October 1980

BPO-S33

SUBJECT: Service to Medicare Beneficiaries — Free Calling for Inquirers Contacting Medicare Part A Contractors

Toll free telephone service (TFTS) is now being provided by carriers processing Part B claims. This service allows access by Medicare beneficiaries to contractors who process their claims. In order to provide the same service to beneficiaries whose claims are handled by intermediaries, *we are now requiring that Part A intermediaries also provide free calling to public inquiries about Medicare business.* (Emphasis added). This can be accomplished either by accepting collect calls or by satelliting on existing Part B toll free lines.

Because of the anticipated low volume of calls and the relative high cost of toll free telephone service, as well as

the difficulty of advertising the appropriate number for use in multiple intermediary States, TFTS for only Part A calls is not authorized at this time. No additional funding is planned and no special reports are required at this time. Standards of service will be the same as for the Part B inquiries:

1. A caller should be able to reach the contractor and encounter no more than a 10 percent chance of getting a busy signal.
2. The caller should be answered by a contractor representative within 20 seconds or have a recording advising of a delay.
3. About 80 percent of the inquiries should be handled to completion during the call.

Each intermediary should advise their HCFA Regional Office of the number or numbers available for Part A inquiries. The Regional Office will transmit the number(s) to Baltimore for posting to beneficiary notices. The Regional Office will also advise the Social Security Offices of the new service.

If there are any questions concerning implementation, you should contact the Regional Office.

HOWARD NEWMAN
Administrator

U.S. Code Cong. and Ad News

# SOCIAL SECURITY AMENDMENTS OF 1965

*For text of Act see p. 305*

House Report (Ways and Means Committee)
No. 213, Mar. 29, 1965
[To accompany H.R. 6675]

Senate Report (Finance Committee) No. 404, June 30, 1965
[To accompany H.R. 6675]

Conference Report No. 682, July 26, 1965
[To accompany H.R. 6675]
Cong. Record Vol. 111 (1965)

DATES OF CONSIDERATION AND PASSAGE
House Apr. 8, July 27, 1965
Senate July 9, July 28, 1965

The Senate Report and the Conference Report are set out.

## SENATE REPORT NO. 404

The Committee on Finance, to whom was referred the bill (H.R. 6675) to provide a hospital insurance program for the aged under the Social Security Act with a supplementary health benefits program and an expanded program of medical assistance, to increase benefits under the old-age, survivors, and disability insurance system, to improve the Federal-State public assistance programs, and for other purposes, having considered the same, report favorably thereon with amendments and recommend that the bill do pass.

## PART I

### I. BRIEF SUMMARY

The overall purpose of H.R. 6675 is as follows:

First, to provide a coordinated approach for health insurance and medical care for the aged under the Social Security Act by establishing three new health care programs: (1) a compulsory hospital-based program for the aged; (2) a voluntary supplementary plan to provide physicians' and other supplementary health services for the aged; and (3) an expanded medical assistance program for the needy and medically needy aged, blind, disabled, and families with dependent children.

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(p. 1944)

Third, to revise and improve the benefit and coverage provisions and the financing structure of the Federal old-age, survivors, and disability insurance system by —

(1) increasing benefits by 7 percent across the board with a $4 minimum increase for a worker who retired at age 65 or older;

(2) continuing benefits to age 22 for children attending school;

(3) providing actuarially reduced benefits for widows at age 60;

(4) liberalizing the definition of disability, providing disabled child's benefits with respect to disability before age 22, providing rehabilitation services for disabled workers, and facilitating determinations of disability;

(5) limiting the duplication of disability benefits and those under workmen's compensation;

(6) paying benefits on a transitional basis to certain persons currently 72 or over who are now ineligible;

(7) increasing the amount an individual is permitted to earn without losing benefits;

(8) amending the coverage provisions by —

(*a*) including self-employed physicians;

(*b*) covering cash tips on a self-employment basis;

(*c*) liberalizing the income treatment for self-employed farmers;

(*d*) improving certain State and local coverage provisions;

(*e*) exempting certain religious groups opposed to insurance;

(9) revising the tax schedule and the earnings base so as to fully finance the changes made; and

(10) making other miscellaneous improvements.

Fourth, to improve and expand the public assistance programs by —

(1) increasing the Federal matching share for cash payments for the needy aged, blind, disabled, and families with dependent children;

(2) eliminating limitations on Federal participation in public assistance to aged individuals in tuberculosis and mental disease hospitals under certain conditions;

(3) affording the States broader latitude in disregarding certain earnings in determining need for recipients of public assistance; and

(4) making other improvements in the public assistance titles of the Social Security Act.

The scope of the protection provided is broadly as follows:

Health insurance and medical care for the needy

(1) Basic hospital plan. — It is estimated that approximately 17 million insured individuals and 2 million uninsured would qualify on July 1, 1966.

(2) Voluntary supplementary plan. — It is estimated that of the total eligible aged of 19 million, from 80 to 95 percent would participate, which would mean approximately 15 to 18 million individuals would be involved.

(3) Medical assistance for needy. — The expanded medical assistance (Kerr-Mills) program is estimated to provide new or increased medical assistance to about 8 million needy persons during an early year of operation. States could, in the future, provide aid to as many as twice this number who need help with medical costs.

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(p. 1945)

## II. PRINCIPAL PROVISIONS OF THE BILL

### A. HEALTH INSURANCE AND MEDICAL CARE FOR THE AGED

The committee's bill would add a new title XVIII to the Social Security Act providing two related health insurance programs for persons 65 or over:

(1) A basis plan in part A providing protection against the cost of hospital and related care; and

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(p. 1946)

#### 1. BASIC PLAN — HOSPITAL INSURANCE

General description. — Basic protection, financed through a separate payroll tax, would be provided by H.R. 6675 against the cost of inpatient hospital services, posthospital extended care services, posthospital home health services, and outpatient hospital diagnostic services for social security and railroad retirement beneficiaries when they attain age 65. Benefits for railroad retirement eligibles would be financed by the railroad retirement tax out of their trust account if certain conditions are met. The same protection, financed from general revenues, would be provided under a special transitional provision for essentially all people who

are now aged 65, or who will reach 65 in the near future, but who are not eligible for social security or railroad retirement benefits.

Effective date. — Benefits would first be effective on July 1, 1966, except for services in extended care facilities which would be effective on January 1, 1967.

Benefits. — The services for which payment would be made under the basic plan include —

(1) inpatient hospital services for up to 120 days in each spell of illness. The patient pays a deductible amount of $40 for the first 60 days plus $10 a day for any days in excess of 60 for each spell of illness; hospital services would include all those ordinarily furnished by a hospital to its inpatients; however, payment would not be made for private duty nursing or for the hospital services of physicians *except* (1) services provided by interns or residents in training under approved teaching programs; and (2) services of radiologists, anesthesiologists, pathologists, and physiatrists where these services are provided under an arrangement with the hospital and are billed through the hospital. Inpatient psychiatric hospital service would also be included, but a lifetime limitation of 210 days would be imposed.

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(p. 1950)

## 3. IMPROVEMENT AND EXTENSION OF KERR-MILLS MEDICAL ASSISTANCE PROGRAM

Purpose and scope. — In order to provide a more effective Kerr-Mills medical assistance program for the aged and to extend its provisions to additional needy persons, the bill would establish a single and separate medical care program to consolidate and expand the differing provisions for the needy which currently are found in five titles of the Social Security Act.

The new title (XIX) would extend the advantages of an expanded medical assistance program not only to the aged

who are indigent but also to needy individuals in the dependent children, blind, and permanently and totally disabled programs and to persons who would qualify under those programs if in sufficient financial need.

Medical assistance under title XIX must be made available to all individuals receiving money payments under these programs and the medical care or services available to all such individuals must be equal in amount, duration, and scope. Effective July 1, 1967, all children under age 21 must be included who would, except for age, be dependent children under title IV.

Inclusion of the medically indigent aged not on the cash assistance rolls would be optional with the States but if they are included, comparable groups of blind, disabled, and parents and children must also be included if they need help in meeting necessary medical costs. Moreover, the amount and scope of benefits for the medically indigent could not be greater than that of recipients of cash assistance.

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(p. 1964)

A threefold approach to meet this national problem has been developed. First, since the committee believes that Government action should not be limited to measures that assist the aged only after they have become needy, the committee recommends more adequate and feasible health insurance protection under two separate but complementary programs which would contribute toward making economic security in old age more realistic, a more nearly attainable goal for most Americans. In addition, the committee recommends, as will be discussed later in this report, a strengthening of the medical assistance provisions of the Social Security Act so that adequate medical aid may be provided for needy people.

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(p. 1965)

The provision of insurance against the covered costs would encourage participating institutions, agencies, and individuals to make the best of modern medicine more readily available to the aged.

The bill specifically prohibits the Federal Government from exercising supervision or control over the practice of medicine, the manner in which medical services are provided, and the administration or operation of medical facilities. Further, the bill specifically provides that a beneficiary may obtain services from any participating institution, agency, or person who undertakes to provide him with the services. The responsibility for, and the control of, the care of the beneficiaries rests with the hospitals, extended care facilities, the beneficiaries' physicians, etc.

In establishing the complementary plans for medical care for the aged in this bill, no special recognition is being given to the lower rate of hospital utilization which might be experienced by aged persons under comprehensive health care plans. However, it is not the intention of the committee by this action to adversely affect those organizations which provide and operate comprehensive health care services. On the other hand, it is the hope of the committee that the development of comprehensive health care plans be encouraged.

## 1. BASIC PLAN — HOSPITAL INSURANCE

### (a) Eligibility for protection under the basic plan

The proposed basic hospital insurance would be provided (on the basis of a new section in title II of the act) for people aged 65 and over who are entitled to monthly social security benefits or to annuities under the Railroad Retirement Act (the administration and financing of benefits for railroad retirement beneficiaries are discussed in sec. (e) p. 38). In addition, people who are now aged 65 or will reach age 65 within the next few years and who are not insured

under the social security or railroad programs would nevertheless be covered under the basic plan. In July 1966, when the program would become effective, about 17 million people aged 65 and over who are eligible for social security or railroad retirement benefits, and about 2 million aged who would be covered under a special transitional provision, would have the proposed basic hospital insurance.

(p. 1966)

Included under the special provision would be all uninsured people who have reached 65 before 1968. As to persons reaching 65 after 1967, they would have to have the quarters of coverage that are indicated in the following table:

*Quarters of coverage required for OASI cash benefits as compared to hospital insurance*

| Year attains age 65 | Men | | Women | |
|---|---|---|---|---|
| | OASI | Hospital insurance | OASI | Hospital insurance |
| 1967 or before | 6-16 | 0 | 6-13 | 0 |
| 1968 | 17 | 6 | 14 | 6 |
| 1969 | 18 | 9 | 15 | 9 |
| 1970 | 19 | 12 | 16 | 12 |
| 1971 | 20 | 15 | 17 | 15 |
| 1972 | 21 | 18 | 18 | [1] |
| 1963 | 22 | 21 | ..... | ..... |
| 1974 | 23 | [1] | ..... | ..... |

[1] Same as OASI.

As indicated in the table, by 1974 the number of quarters of coverage required for cash benefits and hospitalization insurance benefits will be the same and the "transitional" provision will phase out for those reaching age 65 thereafter.

Together, these two groups comprise virtually the entire aged population. The persons not protected would be Federal employees who have actual coverage under the provisions of the Federal Employees Health Benefits Act of 1959. The House bill would also have excluded individuals and their

wives who had the opportunity to come under the Federal act but had not so elected. The committee did not believe that the exclusion of this group was equitable. It believes that actual coverage under the Federal employees program should be the sole basis for exclusion. Others excluded would be aliens who have not been residents of the United States for 10 consecutive years, aliens who have not been admitted for lawful residence, and persons convicted of certain subversive crimes.

Currently, 93 percent of the people reaching age 65 are eligible for benefits under social security or railroad retirement and this percentage will rise to close to 100 percent as the program matures. Thus over the long run virtually all older people will meet the insured-status requirements for the proposed hospital insurance.

(b) Benefits

Persons entitled to benefits under the hospital insurance plan would be eligible to have payments made for inpatient hospital care and for important additional benefits covering posthospital extended care, posthospital home health services, and certain outpatient hospital diagnostic studies.

Benefits would be payable for covered hospital and related health services furnished beginning July 1, 1966. Posthospital extended care benefits would be effective January 1, 1967.

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(p. 1967)

Covered services. — The reasonable cost of service ordinarily provided to inpatients by hospitals (other than certain other items discussed subsequently), including new services and techniques as they are adopted in the future, would be paid for. Services furnished to inpatients by others under arrangements with a hospital could also be covered if the arrangements call for billing for the services to be through the hospital exclusively. Since the reasonable cost of the services would be covered, hospitals would not be deterred, because of nonpaying or underpaying patients in this aged

group, from trying to provide the best of modern care. The following are the major items and services that would be paid for.

(p. 1968)

Hospital room and board would be paid in full in accommodations containing from two to four beds. Payment would also be made for private accommodations where their use is medically indicated — ordinarily only when the patient's condition requires him to be isolated. Where private accommodations are furnished for the patient's comfort, the payments would cover only the equivalent of the reasonable cost of accommodations containing two to four beds; the patient would pay the extra charges for the private room.

Nursing services ordinarily furnished by hospitals would be paid for, but private duty nursing would not be covered.

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(p. 1969)

Supplies and appliances would be paid for under the hospital insurance plan when they are a necessary part of the covered inpatient hospital services a patient receives. For example, the use of a wheelchair, crutches, or prosthetic appliances could be paid for as part of hospital services but payment for hospital services would not cover furnishing these items to the patient for use after his discharge. (However, the cost of using these items after hospitalization might be paid for if needed as part of the posthospital extended care he might receive or it might be provided under a plan for his home health services.) Items supplied at the request of the patient for his convenience, such as television rental in hospitals, would not be paid for under the program.

Conditions of participation. — The committee's bill lists conditions that hospitals must meet in order to participate in the proposed program. These conditions for participation are included to provide assurance that participating institutions are safe, that they have facilities and organization necessary for the provision of adequate care, and that they

exercise their responsibility to discourage improper and unnecessary utilization of their services and facilities. The inclusion of these conditions is designed to support the efforts of the various professional accrediting organizations sponsored by the medical and hospital associations, health insurance plans, and other interested parties to improve the quality of care in hospitals. To allow payments to institutions for services of lower quality than are now generally acceptable might reduce the incentive for establishing high-quality institutions or for maintaining high standards where they now exist.

(p. 1970)

In order to participate in the program, hospitals would be required to be licensed (of course, certification or approval where such procedures are State or local law equivalents to licensing would meet this requirement) and satisfy conditions specified in the bill relating to clinical records, medical staff bylaws, and utilization review. They would also have to meet certain other specified requirements. The bill authorizes the Secretary to prescribe such further requirements as the Secretary finds necessary in the interest of health and safety. The health and safety requirements prescribed by the Secretary (including any requirements requested by a State which are higher than those prescribed for other States), cannot, however, be more strict than the comparable conditions prescribed for accreditation of hospitals by the Joint Commission on Accreditation of Hospitals. Thus, the Secretary could, for example, require participating hospitals to maintain tissue committees which reexamine the condition of the organs removed during surgery and to meet other conditions which the health professions consider necessary to good patient care, but the Secretary could not set the hospital standards above the professionally established level.

Hospitals accredited by the Joint Commission on Accreditation of Hospitals would be conclusively presumed to meet all the conditions for participation, except for the require-

ment of utilization review. (If the Joint Commission adopts a requirement for utilization review, the Secretary could accept accreditation by the Joint Commission as sufficient evidence that a hospital meets all the requirements of the law.) Linking the conditions for participation to the requirements of the Joint Commission provides further assurance that only professionally established conditions would have to be met by providers of health services which seek to participate in the program.

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(p. 1986)

## 3. GENERAL PROVISIONS RELATING TO THE BASIC AND VOLUNTARY SUPPLEMENTARY PLANS

### (a) Conditions and limitations on payment for services

#### (1) Physicians' role

*The committee's bill provides that the physician is to be the key figure in determining utilization of health services — and provides that it is a physician who is to decide upon admission to a hospital, order tests, drugs and treatments, and determine the length of stay. For this reason the bill would require that payment could be made only if a physician certifies to the medical necessity of the services furnished.* (Emphasis added) If services are furnished over a period of time to be specified in regulations, recertification by the physician would be necessary. Delayed physician certifications and recertifications, accompanied by medical and other evidence, to the extent provided by regulations, could be accepted in lieu of timely certifications and recertifications when, for example, the patient was unaware of his eligibility for the benefits when he was treated.

In the case of in-patient hospital services for which payment would be made, the bill would require that a physician certify that the services were required for an individual's medical treatment, or that in-patient diagnostic study was

medically required and that the services were necessary for such purpose. The first physician recertification in each case of in-patient hospital services furnished over a period of time would be required no later than the 20th day of the period. In the case of out-patient hospital diagnostic services, a physician would have to certify that the services were required for diagnostic study.

(2) Utilization review

The committee is particularly concerned that the utilization and review function is carried out in a manner which protects the patients while at the same time making certain that they remain in the hospital only so long as is necessary, and that every effort be made to move them from the hospital to other facilities which can provide less expensive, but equal, care to meet their current medical needs.

(p. 1989)

(b) Exclusions from coverage

The committee's bill would exclude certain health items and services from coverage under both the hospital insurance and the voluntary supplementary medical insurance programs in addition to any excluded through the operation of other provisions of the bill. For example, the bill would bar payment for health items or services that are not reasonable and necessary for the treatment of illness or injury or to improve the functioning of a malformed body member. Thus, payment could be made for the rental of a special hospital bed to be used by a patient in his home only if it was a reasonable and necessary part of a sick person's treatment. Similarly, such potential *personal comfort items and services as massages and heat lamp* (Emphasis added) treatments would only be covered where they contribute meaningfully to the treatment of an illness or injury or the functioning of a malformed body member. Expenses for custodial care would also be excluded.

IN THE
UNITED STATES DISTRICT COURT
For The
NORTHERN DISTRICT OF TEXAS
DALLAS DIVISION

Civil Action No. CA3-79-0529-D

PRESBYTERIAN HOSPITAL OF DALLAS

*Plaintiff,*

*vs.*

JOSEPH A. CALIFANO,
Secretary of Health,
Education and Welfare of
the United States of America,

*Defendant.*

U. S. District Court
Northern District of Texas
FILED
APR 26 1979
Joseph McElroy, Jr., Clerk

By .....
Deputy

## COMPLAINT

1. This is an action to review judicially and reverse a decision of the Provider Reimbursement Review Board, a federal agency established by the Secretary of Health, Education and Welfare pursuant to the authority vested in him by 42 U.S.C. § 139500. The Court has jurisdiction of this action by virtue of the Medicare Act, 42 U.S.C. § 139500(f) (1), as amended.

2. Plaintiff, Presbyterian Hospital of Dallas, hereinafter referred to as, "Presbyterian," is a non-profit corporation organized and existing by virtue of the laws of the State of Texas, located and domiciled in this judicial district at 8200 Walnut Hill Lane, Dallas, Texas 75231.

3. The Defendant herein is Joseph A. Califano, Secretary of Health, Education and Welfare of the United States of America, hereinafter referred to as, "Secretary." Service of citation may be had upon the Secretary at the Department of Health, Education and Welfare, Hubert H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201. A summons should also be served upon the Honorable Kenneth Mighell, United States Attorney for the Northern District of Texas, Earl Cabell Federal Building, 1100 Commerce, Dallas, Texas. Further, a copy of the summons and complaint should be sent by registered mail to The Honorable Griffin Bell, Attorney General of the United States, Department of Justice, Washington, D. C.

4. Presbyterian, at all times relevant hereto, specifically during its fiscal year beginning October 1, 1975 and ending September 30, 1976, operated a fully licensed, acute care hospital in Dallas, Texas, and qualified as a participating "provider of services" under the Medicare Act and regulations thereunder. During this same period, the Blue Cross Association/Group Hospital Services, Inc., hereinafter referred to as "Intermediary" acted as fiscal intermediary for the administration of reimbursements under the Medicare program pursuant to a contract with the Secretary.

5. On January 31, 1977, Presbyterian filed its annual cost report for the fiscal year in question. On September 30, 1977, Intermediary completed its audit of this cost report. Subsequently, three issues were disputed by Presbyterian and Intermediary. Specifically, they are:

(a) Whether or not the expense of free care required under a Hill-Burton interest subsidy is an allowable cost?

(b) Whether or not interest during construction is an allowable cost?

(c) (1) To what extent is Presbyterian's telephone expense an allowable cost?

(2) To what extent is Presbyterian's television expense an allowable cost?

6. Pursuant to the relevant regulations, Presbyterian appealed its dispute with the Intermediary to the Provider Reimbursement Review Board, hereinafter referred to as "Board." A hearing before the Board was held on September 19, 1978. On February 28, 1979, the Board entered an opinion affirming the Intermediary as to all issues in dispute. This case is brought to review judicially that decision by the Board.

**FREE CARE EXPENSE**

7. Since it began operations in 1966, Presbyterian has expanded the size of its facilities and the scope of its services. This expansion program has enabled it to offer an increasingly high level of health care to an increasingly large number of patients. Some, but not all of this expansion, has been financed through the Hill-Burton Act which provides a program of grants, guaranteed loans, and interest subsidies. 42 U.S.C. §291j-1(a)(1) et seq. During fiscal year 1976, Presbyterian received an interest subsidy for four loans made under the Hill-Burton program. These four loans are more fully described as follows:

(a) $3,000,000.00 Second Mortgage Bonds for construction of additional and modernization of existing hospital facilities; Lender: Western & Southern Life Insurance Company, Cincinnati, Ohio; Trustee: Republic National Bank, Dallas, Texas; December 1, 1972. Total interest for fiscal 1976: $225,335; Interest subsidy portion: $87,230. Project No.: 06-C-48-055-0-00-0.

(b) $900,000.00 Third Mortgage Bonds for construction of additional and modernization of existing hospital facilities; Lender: Iowa Public Employees Trust Fund; Trustee: Republic National Bank, Dallas, Texas; December 1, 1972. Total interest for fiscal 1976: $67,533; Interest subsidy portion: $26,142. Project No.: 06-C-48-055-0-00-0.

(c) $418,697.00 Fourth Mortgage Loan for expansion of existing hospital facilities and 27 new beds; Lender: Teacher Retirement System of Texas; October 31, 1973. Total interest for fiscal 1976: $32,477.19; Interest subsidy portion: $12,255.54. Project No.: 06-C-48-955-0-00-0.

(d) $6,222,210.00 First Mortgage Loan for construction of a sub-acute hospital facility — Presbyterian West; Lender: Teacher Retirement System of Texas; January 25, 1975. Total interest for fiscal 1976: $279,093.56; Interest subsidy portion: $99,579.49. Project No.: 06-C-48-089-0-00-1.

The total amount of the Hill-Burton subsidy for fiscal 1976 was $225,207.03.

8. A condition of participation in the Hill-Burton program is the provider's obligation to provide annually a reasonable volume of services to persons unable to pay for them. This free care obligation can be met by any of the three following methods:

(a) Providing an amount of free care equal to three percent (3%) of its operating cost;

(b) Providing an amount of free care equal to ten percent (10%) of the total of all federal assistance received; or,

(c) Providing free care to all of those unable to pay who present themselves for care on an "open door" basis.

42 C.F.R. 53.111(d). Presbyterian elected to satisfy its free care obligation by following the open door policy. Pursuant to that policy, it provided $178,871.00 worth of care to those unable to pay in fiscal 1976.

9. This free care expense is an indirect cost of these loans, and is an obligation which was incurred by Presbyterian so that its facilities could be expanded and improved to treat all patients better, both Medicare and non-Medicare patients alike. Nevertheless, the refusal of the Intermediary

to allow reimbursement based upon the percent of Medicare utilization of the facility, as affirmed by the Board, means that Medicare paients do not bear their fair share of this expense. Instead the full cost of this free care expense must be borne by other patients at the hospital. This result is plainly contrary to the Medicare statutes stating that the program will pay its share of indirect costs. 42 U.S.C. § 1395x(v) (1) (A).

## CONSTRUCTION INTEREST

10. In December, 1974, Presbyterian began construction of a new facility, "Presbyterian West," located adjacent to and connected to its main hospital building. To finance construction of the project, Presbyterian Hospital executed a Deed of Trust Note with Teacher Retirement System of Texas in a principal sum of $6,222,210.00 with interest payable at a rate of 8.4% per annum. Following the generally accepted accounting policy of expensing all interest cost, Presbyterian Hospital expensed the $179,514.00 of construction interest it paid pursuant on this loan during the fiscal year in question. Intermediary disallowed this cost and was affirmed by the Board.

11. The expensing of this indirect cost for the development of a patient care facility to benefit all patients is clearly within the scope of Regulation Sections 42 C.F.R. 405.419 and 42 C.F.R. 405.451. Section 206 of the Medicare manual (HIM-15-1) which is to the contrary should not control over these regulations. The Board's opinion requires that payments be "directly" or "currently" "related to the care of beneficiaries" (i.e. Medicare patients), and upon this basis requires capitalization of construction interest. Significantly, neither the "directly" or "currently" requirement are ever defined, and even more significantly, both terms are ones casually added by the Board. The regulation itself places no qualifiers or modifiers on the requirement that payments merely be related.

12. The refusal by the Secretary to permit Presbyterian's treatment of this construction interest as a current expense is arbitrary and capricious, particularly in view of the extensive body of expert opinion and learned treatises favoring this treatment which is in the record. The contention in the Board's opinion that the dispute here is merely a question of the timing of the recoupment of this interest expense is plainly unreasonable. As pointed out in the Board's dissenting opinion, requiring the capitalization of this expense and its gradual recoupment over a period of years results in an unrealistic value being placed upon the facility which is constructed. Presbyterian is harmed to the extent that it must pay this expense at the time it is incurred but may only recoup Medicare's fair share of the expense years later in dollars whose value will have been seriously debased by inflation. The significant harm which was pointed out in the record, was ignored in the Board's opinion.

## TELEPHONE AND TELEVISION EXPENSE

13. Presbyterian was constructed in such a manner that each private room is equipped with a telephone and a television for the patient's use. Semi-private rooms are equipped with one phone and one television which the two patients share. Since these services are automatically furnished to all patients, their cost is included within the daily room charge and patients are not billed separately for either service.

14. At its hearing before the Board, Presbyterian presented substantial evidence, including the expert opinion of several noted physicians, indicating that telephone and television service is far more than a luxury for the personal comfort of the patient as contended by the Intermediary and affirmed by the Board. The record reflects that telephone and television service has substantial therapeutic value to patients in that it not only eases their discomfort during their period of hospitalization and reduces the amount of nursing care required for them but also that

the services actually promote healing and thereby facilitate patients' recovery.

15. In response to the uncontroverted testimony supporting the therapeutic value of telephones and televisions, the Board's opinion mistakenly infers that these physicians are employees of the hospital, and for that reason, biased. The physicians whose testimony is included in the record are admitted to practice at Presbyterian, but they are in no way employees of said institution. The Board's unfounded claim of bias should not permit the casual dismissal of this important evidence.

16. Regulation 42 C.F.R. § 405.310(j) states that personal comfort items are not reimbursable expenses and includes telephones and televisions within the definition of personal comfort items. This regulation is arbitrary and capricious in that it is not supported by any medical evidence, which is indeed to the contrary, and Presbyterian Hospital believes that the Secretary has abused his discretion in the promulgation of this rule.

## COUNT TWO

## REGULATION 42 C.F.R. § 405.310(j) IS UNCONSTITUTIONAL

17. Presbyterian realleges the allegations contained in paragraph 1, 2, 3, 4, 5(c), 6, 13, 14, 15, and 16.

18. Regulation 42 C.F.R. § 405.310(j) is unconstitutional on its face and in particular as it is applied to Presbyterian and the Medicare patients served by it in the year in question and who will be served by it in the future. This regulation restricts and abridges the patient's right of free communication protected by the First Amendment.

19. The individual patients who were treated during the year in question and those who will be treated in the future do not have sufficient monetary interest to bring suit to protect their rights; Presbyterian has substantial financial interest in being reimbursed for the telephone and television service which it furnished to the patient and

which it will continue to furnish. It sues for its own monetary damages resulting from the refusal of the Secretary to pay for the telephone and television service and on behalf of its patients to be furnished a reasonable means of communication appropriate to the circumstances of their environment while they are confined.

20. While the Medicare patients have no constitutional right to health care, when the Congress decided to provide this service as set forth in Public Law 89-97, as amended, it is obligated to protect the fundamental rights of patients who are the recipients of benefits. Exclusions from coverage are found in 42 U.S.C. 1395y(a). Subsection 6 of section (a) provides that no reimbursement will be paid for items of services "which constitute personal comfort items".

21. The Secretary has construed this language in 42 C.F.R. 405.310(j) and the Provider's Reimbursement Manual to provide that there would be no reimbursement for personal comfort items (telephone and television). Patients in a hospital have severe restrictions placed upon their right of movement and their right to receive visitors. Further, as a result of operations, casts, and other medical appliances they are confined to a bed or in situations where their movement is greatly limited.

22. The telephone and television service which Presbyteriar has provided to all patients, including those receiving Medicare, is a reasonable and appropriate means of providing and protecting the patients' rights of free communication.

WHEREFORE, PLAINTIFF PRAYS:

1. That the Secretary of Health, Education and Welfare be ordered to deliver to this Court the transcript of the hearing held on September 19, 1978, in Case No. 78-96 (Decision 79-D8) before the Board, together with all exhibits and other ancillary documents comprising the record before the Board leading to the decision complained of herein.

2. That the action of the Board refusing to permit Presbyterian to include an allowable or reimbursable cost for

the free care expense described herein, be declared unlawful and set aside.

3. That the action of the Board refusing to permit Presbyterian to include an allowable or reimbursable cost for the construction interest expense described herein, be declared unlawful and set aside.

4. That the action of the Board refusing to permit Presbyterian Hospital to include an allowable or reimbursable cost for telephone and television expense described herein, be declared unlawful and set aside.

5. That this Court determine that the Plaintiff be entitled to include an allowable or reimbursable cost for each of the three items described herein and based upon its percentage of Medicare utilization; and

6. That Medicare patients, while in the hospital, have a right of free communication which is reasonably satisfied and protected by the furnishing of television and telephone services to patients' rooms.

7. That the Secretary's construction of Public Law 89-97, as amended, which is found in 42 C.F.R. 405.310(j) and in the Provider's Reimbursement Manual classifying telephone and television service furnished to patients as luxury items for which reimbursement to the provider will not be paid is unconstitutional.

8. For such other and further relief as this Court may determine to be just and proper.

Respectfully submitted

HARTT AND HARTT
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By

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**From: Defendants' Memorandum of Law in Support of Motion for Summary Judgment**

In Public Law 89-97 (1965), U.S. Code Cong. & Ad. News 1969, 1976, 1977, and 2127, the Social Security Amendments, in the Legislative History part, specifically identified television rental requested by patients as an example of personal comfort items. The controlling regulation, 42 C.F.R. 405.310(j), carries out Congress' intent by stating in part: "no payment may be made for any expense incurred for * * * [p]ersonal comfort items and services (for example a television set, or telephone service, etc.)."

The Defendant is not advocating that any patients be deprived of a private telephone or their having a television set in their rooms. The defendant is merely saying that the cost of those items should not be paid for by Medicare, and in fact the law does not authorize reimbursement for same. The already financially strained Social Security program can ill afford to pay for services which are not in truth needed for the health care of beneficiaries.

# Opposition

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No. 81-264

# In the Supreme Court of the United States

OCTOBER TERM, 1980

PRESBYTERIAN HOSPITAL OF DALLAS, PETITIONER

*v.*

RICHARD S. SCHWEIKER, SECRETARY OF HEALTH AND HUMAN SERVICES

*ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT*

## MEMORANDUM FOR THE RESPONDENT IN OPPOSITION

REX E. LEE
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# In the Supreme Court of the United States

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*ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT*

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## MEMORANDUM FOR THE RESPONDENT IN OPPOSITION

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Petitioner Presbyterian Hospital of Dallas seeks reimbursement under the Medicare Act, 42 U.S.C. 1395, for expenses incurred in providing telephone and television services to medicare patients. However, the Medicare Act explicitly provides that "no payment may be made * * * for any expenses incurred for items or services * * * which constitute personal comfort items" (42 U.S.C. 1395y(a)(6)), and the Secretary has promulgated regulations defining "personal comfort items" expressly to include television and telephone service (42 C.F.R. 405.310(j)). Petitioner therefore asserts no statutory or regulatory entitlement, but rests its reimbursement claim on the alleged First Amendment rights of its patients (Pet. 5-14). The court of appeals, relying on this Court's decision in *Harris* v. *McRae*, 448

U.S. 297 (1980), correctly rejected petitioner's constitutional argument, holding that the government has "no constitutional obligation to *finance* * * * access [to television and telephone service]" (Pet. App. A-7; emphasis in original).

The decision of the court of appeals is correct[1] and we rely fully on its reasoning. There is no conflict among the circuits and further review is therefore unwarranted.

1. As the court of appeals correctly held, petitioner's constitutional argument is foreclosed by this Court's decision in *Harris* v. *McRae*, 448 U.S. 297 (1980). Assuming that the government could not constitutionally deprive a medicare patient of access to television or telephone services, *McRae* makes clear that the government has no affirmative constitutional obligation to subsidize access to such services (448 U.S. at 312-318). As the Court said in *McRae*, "[to] hold otherwise would mark a drastic change in our understanding of the Constitution. It cannot be that because government may not prohibit the use of contraceptives, *Griswold* v. *Connecticut*, 381 U.S. 479, or prevent parents from sending their child to a private school, *Pierce* v. *Society of Sisters*, 268 U.S. 510, government, therefore, has an affirmative constitutional obligation to ensure that all persons have the financial resources to obtain contraceptives or send their children to private schools" (448 U.S. at 318). Petitioner's contention that the government must affirmatively undertake to pay for medicare patients' exercise of their constitutional rights is therefore untenable.

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[1]The court of appeals also held (Pet. App. A-9 to A-16) that petitioner should be reimbursed for expenses incurred in providing free care to indigents under the Hill-Burton Act. Although the government does not believe that this aspect of the court's decision is correct, we have not sought review of that issue here.

2. In any event, a serious question exists concerning petitioner's standing to assert the alleged constitutional rights of medicare patients. It is well-settled that a "plaintiff generally must assert his own legal rights and interests, and cannot rest his claim to relief on the legal rights or interests of third parties." *Warth* v. *Seldin*, 422 U.S. 490, 499 (1975). Petitioner's constitutional rights are not at issue here; the persons whose constitutional claims petitioner seeks to assert are not parties to this litigation; and there is no obvious reason why such persons must rely upon petitioner to protect any rights that they may have.

It is therefore respectfully submitted that the petition for a writ of certiorari should be denied.

REX E. LEE
*Solicitor General*

SEPTEMBER 1981

DOJ-1981-09

# Petitioner's Reply Brief

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No. 81-264

In The
# Supreme Court of the United States

October Term, 1981

PRESBYTERIAN HOSPITAL OF DALLAS,
*Petitioner,*

*v.*

RICHARD S. SCHWEIKER, Secretary of Health and Human Services,
*Respondent.*

## PETITIONER'S REPLY TO MEMORANDUM FOR THE RESPONDENT IN OPPOSITION

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## PETITIONER'S REPLY TO MEMORANDUM FOR THE RESPONDENT IN OPPOSITION

The Secretary's Memorandum makes no pretense of answering the question posed by Presbyterian's Petition for Certiorari. The points urged in favor of the writ have been ignored, and the fact that the Secretary construed 42 U.S.C. 1395y(a)(6) (personal comfort items) to be 42 C.F.R. 405.310(j) (telephone and television) is stated as a self-evident truth precluding constitutional challenge. No constitutional or theological argument is given to support this regulation promulgated to limit the Medicare patient's rights under the First Amendment.

This Court, not the Secretary, is the final arbiter of constitutional questions.

A recent opinion, *Davis v. Passman*, ..... U.S. ....., 99 S.Ct. 2264 (1979) again pointed out that the Founding Fathers expected that the Courts would protect constitutional rights against a regulation such as is presented here and stated:

> "****And in 'its great outlines,' *ibid.*, the judiciary is clearly discernible as the primary means through which these rights may be enforced. As James Madison stated when he presented the Bill of Rights to the Congress:
>
> > 'If [these rights] are incorporated into the Constitution, independent tribunals of justice will consider themselves in a peculiar manner the guardians of those rights; they will be an impenetrable bulwark against every assumption of power in the Legislative or Executive; they will be naturally led to resist every encroachment upon rights expressly stipulated for in the Constitution by the declaration of rights.' I Annals of Congress 439 (Gales & Seaton, eds. 1834)."

It is surprising that the Secretary would not welcome a chance to state that the Medicare patient wherever hospitalized enjoys all of the rights protected by the First Amendment and that a reasonable means of communication should be provided by the hospital where he is confined. This would be a position of high honor; and, any one serving as Secretary can do no more and should want to do no less.

Yet, we find a great reluctance on the part of the three Secretaries who have dealt with this case in its history through court to admit that the patients do have the right of communication when confined in a hospital. The interpretation of Constitutional rights just outlined is obviously not a military secret to be disclosed to the few people who have a high security clearance on a need to know basis. Why the reticence and reluctance to take a position?

The Secretary, like everyone who has held that office, is confronted with the dilemma of budget versus politics. An affirmative answer stating that the Medicare patient has rights under the First Amendment and should be provided with reasonable means of communication would destroy the regulation which calls telephone and television "personal comfort items". This would cost money which the government does not wish to pay. For the Secretary to state affirmatively that the Medicare patient does not have these rights would mean that these elderly people have less status than convicted felons. Such a position would be political suicide even though it would be reversed by the first court to rule on the subject. Therefore, evasion is the defense; the question was not answered; there was no response to Petitioner's argument; and, the Secretary seeks to hold his victory in the Fifth Circuit based upon the confusion of the Medicare and Medicaid programs and with false analogy between the

Hyde Amendment denying funds for abortions and the patient's right to a reasonable means of communication. Again, seeking to win on this position by a technical argument, the Memorandum points out that there is no conflict between the circuits on this point.

Supreme Court Rule No. 17.1 (c) reads in part:

> "When a state court or a federal court of appeals has decided an important question of federal law which has not been, but should be, settled by this Court, or has decided a federal question in a way in conflict with applicable decisions of this Court."

Petitioner stated that this was a case of first impression and raised the question of constitutional rights of Medicare patients. (Petition, p. 6) Obviously, there is no conflict between circuits. To seek dismissal on the grounds of a lack of conflict is either an impertinence or another futile effort to avoid taking a position on the First Amendment.

In answer to this argument Presbyterian would refer to *Griswold v. Connecticut*, 381 U.S. 479, 481 (1965), and *Pierce v. Society of Sisters*, 268 U.S. 510, 535 (1925), both cited by the government, as well as *Eisenstadt v. Baird*, 405 U.S. 439, 443 (1972).

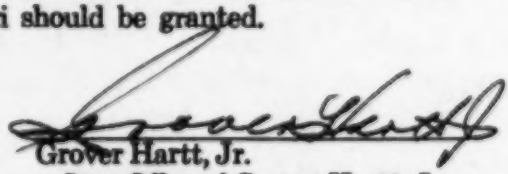
Presbyterian is in a unique position to present this claim. Its method of operation provides telephone and television service to all patients (Petition p. 11). It should not be required to change its method of operation. (Petition p. 11) It has a substantial financial interest for reimbursement for the expense in providing these services for the year 1976 and each of the years thereafter. Unless it changes its method of operation, it will have a continuing expense in providing a means of communication to its patients. It is

entitled to claim the First Amendment rights of its patients under the authority of the cases cited above.

An individual patient at Presbyterian can not sue either the Secretary or Presbyterian for denying a reasonable means of communication because of services now furnished. In juxtaposition consider patients in hospitals where charges are made independently of room costs. They are discharged from the hospital to recuperate. They are in a debilitated condition and many are weakened financially. It is no surprise that the individual patients of other hospitals have not instituted suit even though they were not provided the use of a telephone and television. They can't afford the expense of five years of litigation. They don't have deep pockets.

Presbyterian prefers to stand as a champion of the First Amendment rights of its patients rather than to change its policy, and at some future date be relegated to the position of a defendant that has failed to provide patients a reasonable means of protecting First Amendment rights.

It is respectfully submitted that Presbyterian's Petition for a Writ of Certiorari should be granted.



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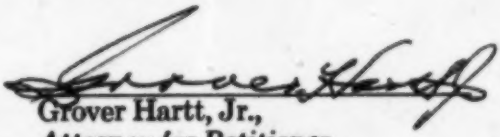
## CERTIFICATE OF SERVICE

I hereby certify that four true copies of the foregoing reply were served on the Solicitor General of the United States, Room 5614, Department of Justice, Washington, D.C. 20530 and a copy was served on the General Counsel of the Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, D.C. 20201 by depositing the same in the United States mail with postage prepaid for First Class mailing service this ... day of September, 1981.



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